

**THE IMPLICATIONS OF CONTRACTING OUT  
HEALTH CARE PROVISION TO PRIVATE NOT-FOR-  
PROFIT HEALTH CARE PROVIDERS: THE CASE OF  
SERVICE LEVEL AGREEMENTS IN MALAWI**

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## Declaration

I have read and understood the school's definition of plagiarism and cheating given in the research degrees handbook. I hereby declare that this thesis is my own work and that, to the best of my knowledge, it contains no previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree of the university or other institute of higher learning, except where due acknowledgment has been made in the text.

Signed.....Elvis Mpakati Gama.....Date.....18 December 2013.....

Elvis Sitithana Mpakati Gama

*“The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart”*

(Geoffrey Rose- The strategy of preventive medicine, Oxford, Oxford University Press, 1992, page 129)

## ABSTRACT

**Background:** The Malawi government in 2002 embarked on an innovative health care financing mechanism called Service Level Agreement (SLA) with Christian Health Association of Malawi (CHAM) institutions that are located in areas where people with low incomes reside. The rationale of SLA was to increase access, equity and quality of health care services as well as to reduce the financial burden of health expenditure faced by poor and rural communities. This thesis evaluates the implications of SLA contracting out mechanism on access, utilization and financial risk protection, and determines factors that might have affected the performance of SLAs in relation to their objectives.

**Methods:** The study adopted a triangulation approach using qualitative and quantitative methods and case studies to investigate the implications of contracting out in Malawi. Data sources included documentary review, in-depth, semi-structured interviews and questionnaire survey. The principal agent model guided the conceptual framework of the study.

**Results:** We find positive impact on overall access to health care services, qualitative evidence of perverse incentives for both parties to the contracting out programme and that some intended beneficiaries are still exposed to financial risk.

**Conclusion:** An important conclusion of this study is that contracting out has succeeded in improving access to maternal and child health care as well as provided financial risk protection associated with out of pocket expenditure. However, despite this improvement in access and reduction in financial risk, we observe little evidence of meaningful improvement in quality and efficiency, perhaps because SLA focused on demand side factors, and paid little attention to supply factors: resources, materials and infrastructure continued to be inadequate.

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## Acronyms and abbreviations

ACB	Ant corruption bureau
AFDB	African development Bank
AIDS	Acquired immune deficiency syndrome
ART	Anti-Retroviral therapy
ANC	Ante Natal care
ARV	Antiretroviral drug
CABS	Common approach to budget support
CAS	Country assistance strategy
CHAM	Christian hospital Association of Malawi
CPI	consumer price index
DFID	Department for international development
DHO	District health officer
DHMT	District health Management team
DIP	District implementation plan
DP	Development partner
EHRP	Emergency Human resource program
EHP	Essential health package
FGD	Focus Group Discussion
GDP	Gross domestic product
GIZ	Deutsche Gesellschaft Fur international zusammenarbeit
GoM	Government of Malawi
GTZ	Gesellschaft Fur Technische Zusammenarbeit
HIV	Human immune virus
HMIS	Health Management Information systems
HSSP	Health sector strategic plan
HRH	Human resource for health
LGA	Local government act
MAM	Muslim association of Malawi
MDG	Millennium development goals

MDHS	Malawi Demographic health survey
MDGS	Malawi development and growth strategy
MPRS	Malawi poverty reduction strategy
MoH	Ministry of Health
MOU	Memorandum of understanding
NAO	National Audit Office
NCA	Norwegian church council
NGO	Non governmental organisation
NHA	National health accounts
NORAD	Norwegian agency for development cooperation
ODA	Official development assistance
OECD	Organisation for economic co-operation and development
PHAM	Private Hospital association of Malawi
POW	Program of works
SLA	Service level agreement
SWAp	Sector wide approach
USAID	United states agency for international development
TCE	Transaction cost economics
WHO	World health organisation
VHF	Vertical health funds
VDRL	Venereal disease research laboratory
ZHA	Zone health administration

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## **Chapter 1: Background to the study**

### **1.0 Introduction**

The Malawi government in 2002 embarked on an innovative health care financing mechanism called Service Level Agreement (SLA) with Christian Health Association of Malawi (CHAM) institutions that are located in areas where people with low incomes reside. The rationale of SLA was to increase access, equity and quality of health care services as well as to reduce the financial burden of health expenditure faced by poor and rural communities (MNHA, 2005).

Using the SLA mechanism, CHAM facilities are contracted by the Ministry of Health (MoH) to provide health care services to people within their catchment area free of charge. The government pay the facilities for the materials used in treating the people based on agreed price list. The main objectives of the SLA between government and CHAM institutions is to improve access, equity, quality and reduce the financial burden of out of pocket expenditure on health care (Meis and Eldridge, 2007; MOH, 2008; EHP; SWAp; GTZ, 2009; GIZ, 2011).

While contracting out of health care provision is relatively new in Malawi, empirical evidence and experience from countries including Pakistan, India and Denmark (De Costa and Diwan, 2007; Nishtar, 2006; Asante and Zwi, 2007; Vrangbaeck, 2008) suggests that contracting out of health care provision to private health care providers has the potential to mobilize additional resources for the national health system. Nishtar (2004) has stated that a public private mix is fostered when government or its agencies contract with the not for profit private health sector to increase health care coverage, or the for profit private health sector for technical expertise among other things. On the practical side Nishtar (2006) has shown that the involvement of the private health sector has increased the capacity of primary health care and health outreach programmes in Pakistan. Similarly, it has been argued that, allowing the public and private health sectors to work together under a formal and properly regulated contract in the provision of health care has the potential to foster the capacity of the health system, through sharing skilled human resources, financing of services, physical resources utilisation and limiting duplication of services (Aljunid, 1995; Mills et al. 2002; Bustreo, Harding and Axelsson, 2003; Thaver et al. 1998).

The foregoing suggests that contracting out is one of the principal mechanisms that some governments are using to harness private health sector resources in order to achieve national health policy goals (Taylor, 2003). In a contracting out arrangement between public sector agencies and private health care providers, money is transferred from government as purchaser to a private healthcare provider in exchange for the delivery of specified health care services. However, like in all other contractual arrangements, there are bound to be goal conflicts within government between various public agencies and between the government (purchaser) and private health care providers (agents), but if the potential gains from private provision of health care services are sufficiently large, due for example, to availability of qualified staff, modern medical facilities, infrastructure and superior private provider efficiency, then contracting out could produce a better outcome.

Despite contracting out being widely used by public agencies to procure a wide range of public service, they suffer a number of limitations such as introducing new categories of cost (Chalkley and Malcomson, 2000), due to the cost of awarding, managing and monitoring contracts. There is a risk therefore that contracting out may end up being more expensive than the traditional procurement mechanism. Similarly, given that private providers may have various motives when going into such contracts, some view such transfer of public resources as benefiting or enriching the private providers at the expense of the general populace. However, in the absence of best alternatives these private providers are used in an attempt to meet public health goals through a combination of public financing and private means (Harding and Preker, 2003). This therefore suggests that contracting has potential benefits as well as limitations and risks.

## **1.2 Rationale for the Study**

The overall aim of this investigation was to explore and better understand contracting out of maternal and child health care provision under SLA and its implications for access and utilisation of maternal and child health care services at CHAM institutions. Understanding the stated and revealed objective functions of the government agencies, CHAM and development partners and how these three actors interact through SLA contracts will improve knowledge and understanding of factors that facilitate or impinge the success of SLA. This knowledge and understanding may help health policy makers in identifying ways to encourage the factors that facilitate contracting

out health care services and strategically address factors that impinge on the success of health care provision contracts. This will facilitate the use of appropriate public and private health care provider contracting out arrangements that could improve access, utilisation and quality of health care services.

### **1.3 Significance of the study**

The thesis aims at being scientifically and socially significant. The scientific significance lies in the application of principal agent model and Transaction cost economics (TCE) in the contracting out of health care services in a developing country setting. As discussed in the previous section, there already has been some attempt to apply principal agent model and TCE analysis in the health sector. However, there has been limited use of TCE in situations involving low income countries. To warrant a fruitful application in contracting out in low income countries it is necessary to understand the specific characteristics of private not for profit organisations that can be taken into account in these context.

The social significance can be found in the analysis of alternative institutional arrangements at the local government level. Currently, the general tendency is towards contracting out to private health care providers. The contracting out arrangement was being implemented in the expectation that they will perform more efficiently than public provision of health care services. The question is whether this is really the case, especially when not only production costs are taken into account, but also transaction costs. Furthermore, the social significance can be seen in informing choice between alternative governance structures in the provision of healthcare services through better understanding of welfare losses due to transaction costs.

### **1.4 Structure of the thesis**

The first chapter presents the background, rationale and the significance of the study as well as the structure of the thesis. Chapter 2 describes the development of a modern health system in Malawi, major rules, regulations, policies and recent changes in some important laws that are governing the operation of the health sector. In Chapter 3 the general definition of a contract and contracting out in general as well as the application of contracting out in health care service provision is provided. In addition, a description of transaction cost economics (TCE) and



principal agency theory (PAT) on which the paradigm of contracting out of health care services has been based, as well as their limitations are outlined. This is followed by a review of empirical evidence in the literature on contracting out of health care services from both high and low income countries. Chapter four presents the theoretical framework and describes the research methods of the study. An outline is given of the various data gathering techniques: clients exit interview surveys, health worker surveys, focus group discussions, in depth interviews and case studies.

Chapter 5 presents findings on the policy of contracting out health care services, particularly maternal and child health care services under SLA. The chapter summarizes the environment in which SLA contracts were undertaken by discussing responses of survey respondents and the perspectives of various informants in the case study site. This leads to a discussion of the challenges posed by SLA to both CHAM facilities and Ministry of Health representatives at the district level, which focuses on: capacity problems, sustainability, contract renegotiations, delayed or non-payment of SLA bills, delayed contract renewals, shortage of essential drugs and other supplies. The introduction of SLA in CHAM facilities was expected to improve access and utilisation of the contracted services. The findings show that SLAs had resulted in increased utilisation of maternal and child health services. However, the increase in utilisation was short lived due to: funding constraints, infrastructure limitations, inadequate skilled health workers and lack of institutions to support the initiative. The imbalances between demand and supply factors have constrained the operationalization of SLAs.

Chapter 6 presents findings on the objective functions of government, development partners and CHAM facilities. In assessing the objective functions, the study used stated objectives as documented in the organisations documents and revealed objectives through the behaviour of the actors. In general, the findings show that both organisations and individuals involved in SLA had similar stated objectives. However, their revealed objectives differed from stated objectives. The divergence between stated and revealed objectives partly explains some of the challenges that SLAs are experiencing.

Chapter 7 presents findings on the multiple agency relationships within the disparate organisations involved; how they constrain each other and the impact of such constraints on SLAs. The chapter outlines the challenges of organisational differences, power relations, information gaps and transaction costs. The study findings show that government, CHAM and DPs constrain each other through various mechanisms including: bureaucratic systems, poor governance and accountability, unpredictability of financial flows, capacity problems, non-disclosure of external financing, reluctance to implement government policy and by-passing government structures in favour of NGOs. These kinds of constraints raise concerns about the effectiveness of SLAs.

Chapter 8 provides a discussion on various themes that arose in the results chapters and relates them to the economic theories of principal agent and transaction cost economics. In particular, the chapter has discussed how SLAs were implemented and what has been learnt. This covers contractual obligations and performance within the broad objective of SLA between CHAM facilities and government agencies; how effectively SLA was implemented, how CHAM facilities and DHOs responded to its mechanism and how the discrepancies of demand and supply factors impacted the provision of health care services. The last section of the chapter is focused on elaborating whether SLA is a donor driven idea or Malawi government owned. This is necessary owing to the involvement of DPs in the Malawi health sector, their influence, how they shaped the incentive environment of government and CHAM, the challenges of donor dependency and their implications for the sustainability of health care financing in the country's health system. Important questions posed in this section are; Is SLA a donor driven idea? Who wants SLA to work?

Chapter 9 presents the conclusion of the thesis, implications for policy and practice, contribution to the body of knowledge and an agenda for further research on the subject of contracting out through SLAs.

## **Chapter 2: Developments in the health sector in Malawi**

### **2.0 Introduction**

This chapter will discuss the background of healthcare provision and relevant recent developments in the Malawi health sector. The first section elaborates on the development of the modern health care system, health care financing, health care delivery system and the involvement of the private sector in health care provision. The second section discusses major health sector policies that have shaped the current health system and the emergence of CHAM and its roles in the health system through various mechanisms including service level agreement.

### **2.1 Background information-**

The delivery of health care services in Malawi has experienced many overlapping phases, notably:

- a- The era of ignorance when little or nothing was known about diseases and how to treat them.
- b- The development of the indigenous health care system based on the knowledge of disease and various approaches to control it.
- c- The spread of Arabic civilisation, including its medical practices.
- d- The introduction of western health care systems from the nineteenth century onwards

The western health care system dates back to the time when missionaries started coming to central Africa. Through their efforts churches, healthcare institutions and education facilities were established (King, 1966; Stock and Anyinam, 1992; Falola and Ityavyar, 1992). These early missionaries preferred to settle in very remote areas to serve needy populations. It is therefore suggested that missionaries were the first to introduce modern health care services to such areas. Many changes have taken place in the health sector since then (Falola and Ityavyar, 1992; King, 1966). After independence in 1964, the Ministry of Health (MoH) assumed the role of main financier and provider of health care services, but worked in collaboration with the existing mission health care providers and health clinics operated by statutory corporations (NSO,

2004). Most of the health services were oriented towards curative, rather than preventive health care services and involved interventions that were largely supported by various donors (Ngalande Banda and Simukonda, 1994; Ngalande Banda and Walt, 1995).

To provide health services, the central MoH developed its own policies, implemented and regulated them, evaluated its own performance and developed the human resources required for the health sector. This was deemed to be inefficient as the MoH was not able to provide the necessary healthcare services due to low levels of skilled personnel and inadequate health care facilities among other factors. Among suggestions to improve performance was to decentralise roles and responsibilities. This resulted in the introduction of the Malawi Decentralisation Act and amendment of the local government act in 1998 (MoH, 2008).

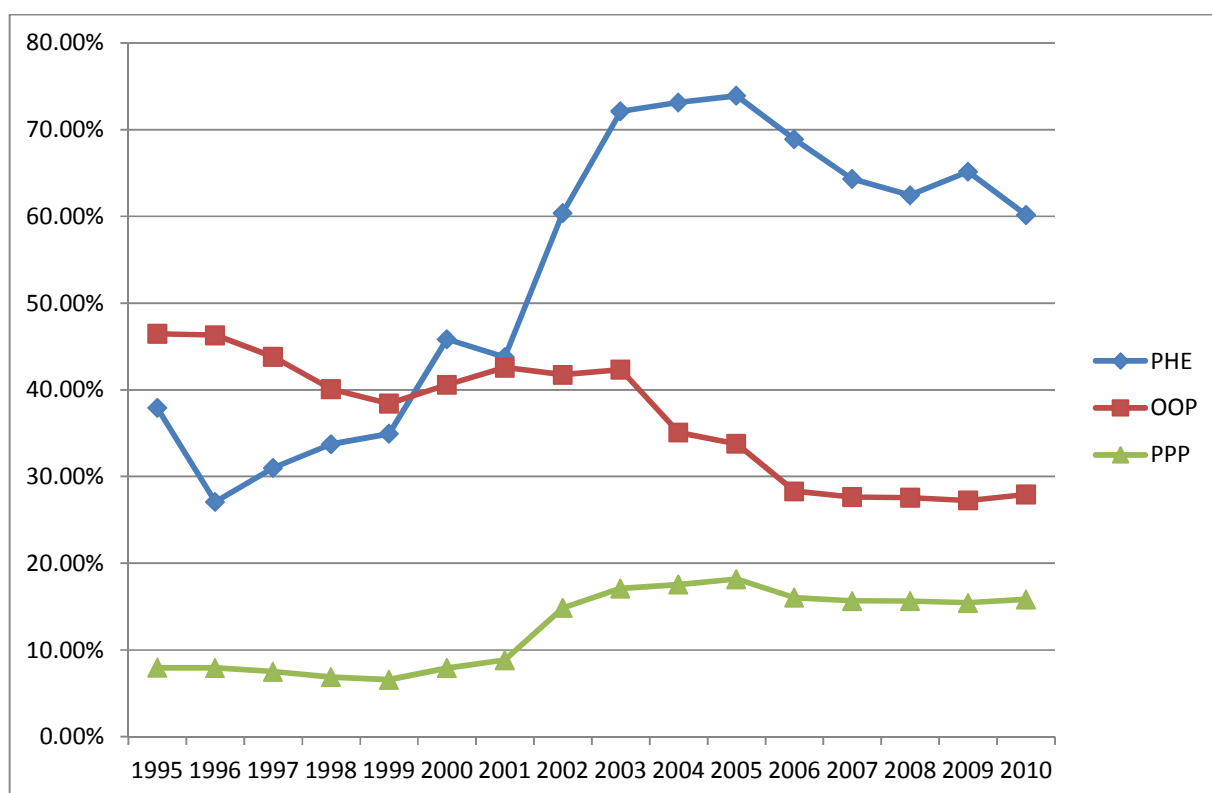
## **2.2 Health care financing**

The health sector in Malawi is financed through taxes, international donors and private expenditure on healthcare. Public health care expenditure (PHE) which consists of recurrent and capital spending by government budget, external borrowings and grants (including donations from bilateral donors, international agencies and nongovernmental organisations that are channelled through government) accounted for 60% of the total expenditure on health in 2010, lower than in previous years as illustrated in figure 2.1, while the private sector accounted for 40% of the total health expenditure (World Bank, 2012). Public health care expenditure was generally high compared to many African countries in the preceding years owing to large financial resources committed for HIV/AIDS and reproductive health programs by development partners and international organisations such as Global fund.

Due to low public expenditure on health, the private sector contributed a considerable share in health care financing, particularly in the form of out of pocket payments (OOP) as illustrated in figure 2.1. The private expenditure on health comprises of workplace insurance and out of pocket payment that are made at the point use. Overall, private sector expenditure on health care (inclusive of institutional and out of pocket payments by households) accounted for 40% of total health expenditure in 2010. Out of this share 15.84% came from third party health insurance schemes (PPP) mostly from corporate employers through self-insuring work-based health

programs, while 28.5% came from households out of pocket expenditure on health. Out-of-pocket health care expenditures are mostly in the form of fees to providers; direct payments for purchases of over-the-counter drugs and health commodities that health facilities cannot provide.

**Figure 2.1: Sources of Health care financing from 1996 to 2010**



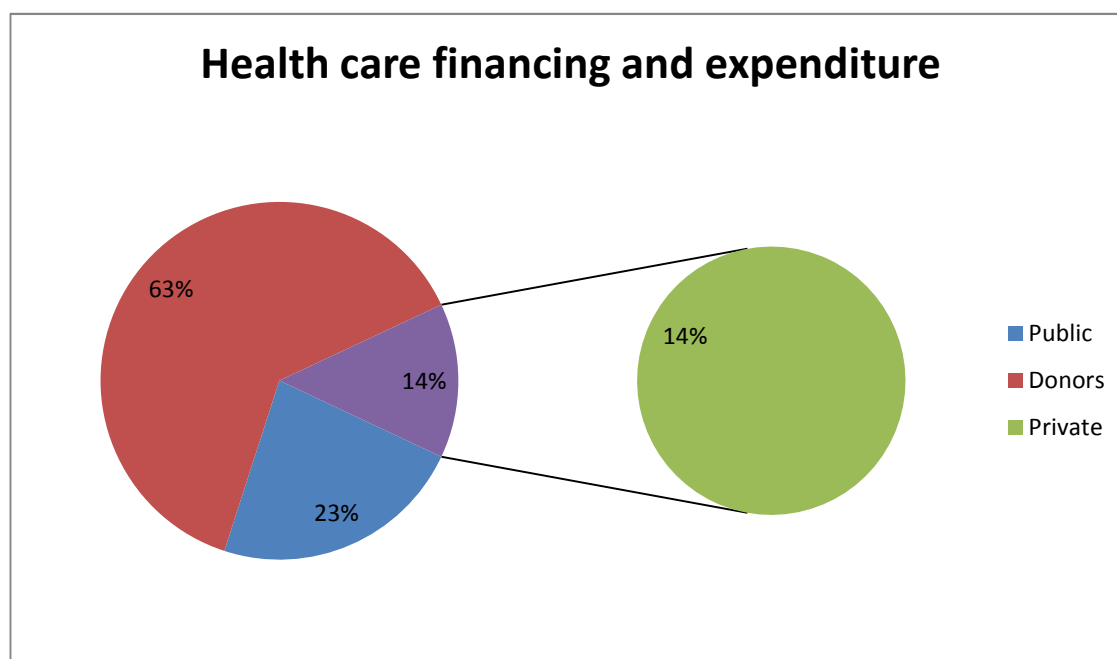
Source: Constructed by author using data from WHO, 2012

This included expenditures on socially marketed commodities such as bed nets, oral rehydration salts and contraceptives (NHA, 2007; GIZ, 2011). Health insurance is in its infancy in the country and provides coverage mostly to better-off families, especially those employed in the formal sector. There are currently over five registered health insurance companies that are involved in health risk pooling.

However, despite having various health care financing mechanisms, the level of health care financing in the country is generally low, in absolute terms and relative to other countries in the region. Malawi's per capita health expenditure in 2010 was only \$26 (World Bank, 2010) which

is less than the \$34 recommended by WHO commission for macroeconomic and health for the delivery of essential health care services.

**Figure 2.2: Breakdown of health care financing and expenditure in Malawi- 2010**



Source: Constructed by author using data from NHA, 2010

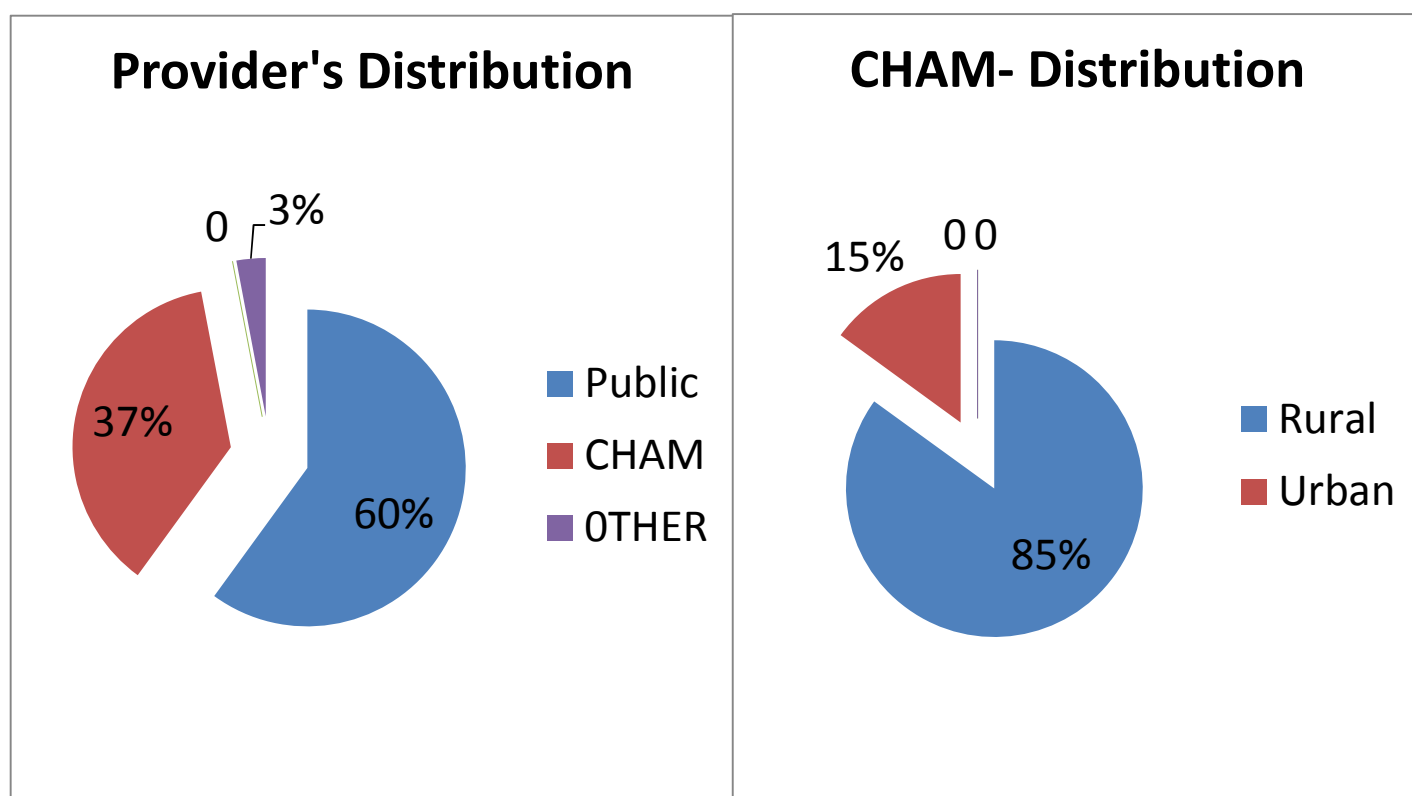
Figure 2.2 shows that in 2010 development partners contributed 63% of the overall health budget while the government and the private sector contributions were 23% and 14% respectively. The 14% from private sector comprises of 28.5% from prepaid schemes and 71.5% from out of pocket payment.

### 2.3 Delivery of health care

Malawi uses a dual health care system, whereby both public and private health care providers coexist in the provision of health care services to the general populace. Government institutions provide free health services through health centres and hospitals while private health providers charge user fees. Based on the number of health facilities, population in the catchment area, hospital beds and number of skilled human resources, as illustrated in figure 2.3, it is estimated that government provision accounts for 60 percent of total health care provision, supplemented

by CHAM institutions that provide 37<sup>1</sup> percent of health care facilities in the country, but impose user fees at a supposedly cost recovery rate (CHAM and NCA, 2009; CHAM, 2009). The remaining 3 percent is provided by private for profit and NGO providers. Health care service facilities are owned by public, private not-for profit organisations (for example CHAM affiliated providers) and private for- profit entities.

**Figure 2.3: Health care provider's distribution based on facilities<sup>2</sup>**



Public facilities include the teaching hospitals and all government facilities (hospitals, health centres, clinics and community outreach centres). Private facilities include hospitals, clinics, maternity wings and pharmacy shops (Ngalande Banda and Simukonda, 1994; Ngalande Banda and Walt, 1995). However, the counting of facilities irrespective of their type and size as illustrated in figure 2.3 does not provide a true picture of the capacity of some of the facilities to

<sup>1</sup> In the latest version of Malawi NHA 37% was quoted, but according to one of the authors this figure is often quoted but has never been substantiated. A press lease by CHAM in September, 2006 stated that it was 40%.

<sup>2</sup> Facilities that were counted constituted teaching hospitals, general hospitals, health centers and clinics.

provide quality health care. For instance, counting a teaching hospital and a health centre as an equal unit may mislead decision makers when planning and allocating resources.

**Figure 2.4: Types of public health care facilities**

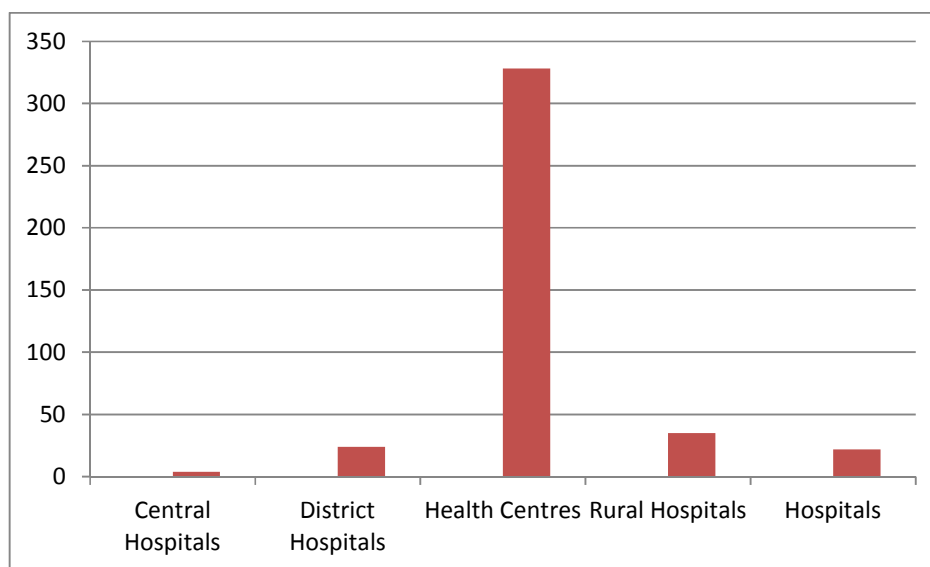


Figure 2.4 illustrates that there are various types of public health care facilities in Malawi, and that a majority of them are health centres.

## 2.4 Private sector involvement in healthcare provision

The involvement of the private sector in health care provision in Malawi dates back to the time before independence when hospitals run by missionaries coexisted with public hospitals and this has been documented by various authors (Ngalande Banda and Walt, 1995; McPake and Ngalande Banda, 1994; Ngalande Banda and Simukonda, 1994; Makoka, Kaluwa and Kambewa, 2007). While some of these studies have managed to show the presence and the important role the private sector plays in Malawi, how private providers interact with the public providers has received less attention.

To understand the interaction of public and private health sectors and how that affects the provision of health care services in the health system, it is necessary first to define what the terms



public and private sector mean. The definitions of public and private sectors in this study are adapted from Hanson and Berman (1998) and Nishtar (2004), where *public health sector* refers to national, regional and district governments, Municipal administrations, local government establishments and all other government as well as inter-governmental agencies with the mandate to deliver health care. The word *private* denotes two sets of structures; the private for profit which encompasses commercial enterprises of any size and non profit private representing the Non Governmental organisations (NGOs), religious mission institutions; philanthropists and other non- profit entities which fall outside the direct control of government. These private providers can operate as hospitals, clinics run by doctors, nurse midwives and paramedic workers, diagnostic facilities, e.g. laboratories and radiology units, pharmacies and itinerant drug sellers (Mills, et al., 2002). In some countries, for example in Malawi, religious mission health providers and NGOs receive substantial operating subsidies from government; however, this does not change their status to public institutions by the definition adopted.

Before 1987 private provision of health care services was restricted and health care professionals employed by government were not allowed to operate private health care facilities. In 1987 the government passed legislation that lifted restrictions on private practice. The 1987 Medical Practitioners and Dentist Act allowed qualified health care professionals working for government to operate private health care facilities with the objective to retain skilled health workers who were migrating to high income countries.

The relaxation of policies restricting private practice by government medical personnel coincided with the expansion of the drug outlets and emergence of a health insurance sector. While we recognise that the private health sector is comprised of both private for profit and private non-profit components, this study will focus on the private non-profit, particularly CHAM facilities because of their special relationship with the government through the subsidies that they receive and involvement in SLAs.

There are various mechanisms through which public and private providers interact in different countries. The mechanism of interaction will in general depend on the country's economic development stage, resources, epidemiological challenges and culture. However, Aljunid (1995)

and Mills, et al.( 2002) have shown that despite these country specific factors, public and private health sectors in most countries interact with each other through regulations, human resource, sharing, patient referral, disease notification, sharing training costs and outputs , financing (e.g. public hospitals operating private wards which are paid by private providers, public providers providing subsidies to the private sector), contracting, sharing of facilities (e.g. intensive care units, labour and maternity wards and radiology) and purchasing of drugs through the central medical stores which are managed by public providers. There is compelling evidence that the public and private health care sectors in Malawi interact with each other as described here.

## **2.5 Health sector policies**

In this subsection, relevant policies in the health sector will be explored in order to determine how they have contributed to the overall health sector goals of the nation. The policies include; sector wide approach, program of works, essential health package, emergency human resource plan and decentralisation.

### **2.5.1 Sector Wide Approach - SWAp**

Traditionally, development partners (DPs) provided aid in the form of self contained health projects, each funded by their own DP. However, this approach attracted criticisms for being DP driven and leading to fragmentation and duplication. In response, some DPs reformed their methods of aid delivery and sector wide approach (SWAp) emerged. A SWAp is usually characterised as an approach in which some DPs support a shared sector-wide policy and strategy which has clear sector targets and is result focused (Pearson, 2010). Thus, under the SWAp, project funds contribute to a sector-specific umbrella and are tied to a defined sector policy under government authority. In essence, SWAp calls for a partnership in which DPs and government change their relationship (Hutton and Tanner, 2004).

The SWAp in Malawi was developed in 2003 on the principles of partnership and collaboration with the goal of sustained development in health care delivery (Pearson, 2010). It was designed to increase efficiency and effectiveness of resources in the health sector through a coordinated and negotiated programme of works (POW), rather than using fragmented vertical health funds (VHF) which created “islands of excellence” operating within an ever weakening public

health system. The VHF targeted narrowly defined objectives and was often free to work inside or outside government. Considering the volume of resources they managed and the scale of their operations, VHF had significant indirect and direct effects on government programs creating unintended consequences e.g. leaving significant financial gaps in relation to health systems, including infrastructure and recurrent costs (Pearson, 2010).

Since its inception the SWAp has supported the development and implementation of key health sector reforms and policies. Some of the institutional and policy developments attributed to SWAp include the following; Program of works (POW) for the health sector, an outline of priority health activities to be implemented by the Ministry of Health, DPs and major not-for-profit organization, including strategies and resources required for these activities; Essential Health Package (EHP), a defined range of cost-effective health care interventions that are provided in all public health facilities free of charge to all Malawians; public private partnership through SLAs to expand health care service delivery and the emergency human resource program (EHRP), an emergency program to increase the number of skilled health care personnel in the health sector (MoH, 2008).

### ***The challenges of SWAp***

- SWAp explicitly mandates the Ministry of health with the leadership, however, owing to limited leadership capacity, frequent change of senior management and low priority of sectoral collaboration, nationals are not able to fully implement health sector planning, financial management and improve health management information systems as emphasized in SWAp.
- The unwillingness of some donors to join the SWAp for various reason leading to less developed SWAp. For instance, despite being among the major donors in Malawi, USAID, Gates Foundation and GFATM among others, generally they do not participate in the health SWAp.
- Significant resources have been made available due to SWAp; however, some have not been put to their best possible use due to continued regional imbalances in allocation of

resources and also due to the allocation of resources to services which although within the EHP, do not represent the most cost effective use of scarce resources (Pearson, 2010).

- There are concerns that heavy investment in certain areas may be undermining progress in other areas e.g. they seem to put more emphasis on disease interventions, neglecting health care infrastructure and institutions governing health care provision.
- Investing in seemingly cost-ineffective interventions due to priority differences of those involved in SWAp. For instance, ARVs account for a large share of investment but are seen as cost- ineffective by some actors in SWAp, while others view them as cost – effective.
- Emphasis of the EHRP has been on increasing the number of medical staff and less attention has been given to improving staff performance
- One often implicit aim of a SWAp is to reduce the transaction costs of government activity (Pearson, 2010). However, it is not clear that this has been achieved, considering the sheer size of Planning and Review meetings along with the heavy day to day involvement of development partners in many aspects of SWAp management. These have been argued to involve large transaction costs for government and drain capacity (World Bank, 2010).

Despite the challenges of SWAp as outlined above, Pearson (2010) has stated that the SWAp in Malawi has made considerable progress despite weak institutions to support transparency and accountability by government officials as well as government's inability to generate enough resources for the operation of the health sector.

### **2.5.2 Programme of works (POW)**

The government, in collaboration with development partners, finalised a six years joint program of works (POW) for the health sector in 2004. The joint Program of Work (POW) 2004 – 2010, outlined health sector priorities, key sectoral activities, implementation strategies, resource implications as well as monitoring and evaluation mechanisms. At the core of the health care delivery and development strategy was the Sector Wide Approach (SWAp) which brought together all the partners participating in health sector activities namely, the MOH, CHAM, NGOs, development partners, civil society, the private sector both for profit and not for profit,

and communities. Health sector targets to be achieved during the plan period of the POW were agreed to by Consensus (Joint SWAp POW, 2004-2010). The (POW) for health was developed on the basis that it would be used to establish EHP and was operationalized through consolidated activities from the district implementation plan (DIP) (GTZ, 2007; SWAp, 2010).

### **2.5.3 Essential health package (EHP)**

The EHP entails minimum packages of health care services to be provided free of charge at the point of delivery for all Malawians and has the following objectives:

- To contribute to reduce poverty
- Increase the efficiency of publicly funded health services
- To improve equity of access to health services through guaranteeing access to a minimum standard of health care for everyone
- As a tool for priority setting
- As a basis for the sector wide approach

This is in line with the Malawi Poverty Reduction Strategy Paper (MPRS). The EHP focuses on conditions and health care services that disproportionately affect the health of the poor and disadvantaged populations. It consists of a group of cost-effective and proven interventions which are combined and delivered together so as to reduce the cost to patients. This type of packaging of health services combines those services that can be delivered within the same facility and using the same level of technology. However, due to a mismatch between health care resources and health care needs, the government can only provide a limited range of priority health care services that are deemed to be cost-effective.

The costing of the EHP involved a number of different processes and stakeholders at various stages. Much information was obtained through consultation with technical programs, district health management teams and senior staff from government health care facilities. In addition to this, Ministry of Health documents such as plans, budgets, technical guidelines, consultancy reports and research documents were reviewed. The EHP was originally estimated to cost US\$17.53 per capita. However, the costing was revised in 2007/8 to US\$28.03 per capita after including some elements that were not included in the original scheme. It was reported that medical staff were being diverted from EHP to ART clinics (before becoming part of the EHP in

2007) and other non EHP interventions. The revised EHP incorporated ART and HIV/AIDS related care, new artemisinin combination therapy and a maternity “Road Map” to increase institutional deliveries attended by skilled health care personnel such as midwives (Bowie and Mwase, 2011). The increase in the cost of the EHP was funded by the Global fund and this raises questions of sustainability.

The EHP forms the basis upon which the districts will develop their District Implementation Plans (DIPs). DIPs provide for the delivery of health care services that are covered in EHP through a referral system which links community level, health centre and the first referral (district) hospital level including CHAM facilities. The EHP can therefore be argued to be the policy that has lead to SLA between MOH as a way to enable people to access EHP services (CHAM, 2009; CHAM and NCA, 2009).

However, the appropriateness of EHP is generally questionable on two fronts. First, EHP includes some health services which are argued to be cost-ineffective, such as the ART /ARV. Second, health services outside the EHP are provided , for instance, the national health accounts (NHA) have shown that MOH continues to provide free care for services that fall outside EHP e.g. the substantial cost of overseas referrals (Bowie and Mwase, 2011). Given that under EHP, facilities continue to provide cost-ineffective services and those outside EHP, but paying less attention to major causes of burden of disease like mental illness and road traffic accidents as reflected in EHP documents, renders EHP to be inappropriate.

#### **2.5.4 Emergency Human Resource Programme (EHRP)**

The Government through the Ministry of Health and with support from its development partners has implemented various interventions aimed at addressing the human resources for health (HRH) crisis. One of the notable interventions in HRH was a six year Emergency Human Resource Plan (EHRP) that started in 2005. The EHRP had a number of activities mainly focusing on issues of retention, deployment, recruitment, training and tutor incentives to rectify skill shortages in the health sector. The EHRP aimed to attain at least the following staff targets broken down by cadre: 28% physicians, 49% nurses, 34% clinical officers, 40% medical

assistants, 18% laboratory technicians, 37% pharmacy technicians and 18% environmental health officers (EHRP, 2004).

Among the strategies used to achieve the objective include the introduction of incentives like provision of a 52 per cent salary top-up for the eleven professional and technical cadres working in the public health sector and CHAM (GTZ, 2007; SWAp, 2010; MoH, 2004, 2008). However, the EHRP review (2010) has argued that, the determination of the allowance was based on 52% of an individual's monthly basic pay, implying that the allowance is subject to income tax, such that after tax, the real increase is only 20%. Furthermore, the sustainability of top-up allowances for health professionals is questionable. Chirwa, Jimmy-Gama and Mpakati, 2011 have documented that, *“an informant observed that sustainability of 52% salary increment relying on DFID funding was a challenge”* (Chirwa, Jimmy-Gama and Mpakati, 2011, page 37).

Public hospitals also implemented incentive initiatives to supplement central Government in incentivising health workers, and one such initiative was the introduction of a relief scheme which involved health workers who when off-duty would be assigned to cover where there was a shortage, and would be compensated financially for the extra work. The EHRP has enabled more staff to be trained, recruited and retained, so providing better clinical cover in health care facilities. During the 2007 SWAp midyear review meeting, one of the milestones agreed under the Human Resource Pillar One of the programme of work was the need to assess various incentive initiatives that were being used to establish what impact they were having in tackling HRH shortage.

An EHRP evaluation report (2010) noted that Malawi had made some cadre specific achievements, however, some of these achievements are not necessarily addressing in full the original HRH crisis in the critical cadre such as of nurses and midwives. Further, the review showed that Malawi made achievements in producing more medical doctors but failed to reach targets on dental therapists, physiotherapists and radiography technicians.

### 2.5.5 Decentralisation process

The World Bank has defined decentralisation as,

*“The transfer of responsibility for the planning, financing and management of certain public functions from the central government and its agencies to field units of government agencies, subordinate units or level of government, semi-autonomous public authorities or corporations, or area-wide, regional or functional authorities”* (World Bank, 2001).

In Malawi the decentralisation policy was adopted in 1998 following the enactment of an amended local government act (LGA) in the same year. Thus the LGA is the legal framework within which the decentralisation policy operates. The ministry of health has since decentralised some of the operations below the district level creating lower level units of operations like central and district hospitals as cost centres (GTZ, 2007).

In line with the decentralisation policy, the central level has no direct management relationship with districts. Its roles are policy making, development of national strategies, external relationships, regulation and monitoring of services, and technical support. This means that the Ministry has the responsibility to identify important principles to be followed to ensure that the health care system is managed in the national interest.

Following decentralisation, MoH is responsible for policy formulation, planning, resource mobilisation and donor coordination. Health care provision is organised along a five tier system, zone, central, and district, sub-district and community levels. At the district level, curative services are delivered at central hospitals and public health services are organised by the District Health Management Team- DHMT. The Zone Health Administration (ZHA) provides supervision and management support to the districts and sub- districts within each zone. At the district level curative health care services are provided by district hospitals, some of which are mission based. At the sub district level both preventive and curative health care services are provided by health centres as well as outreach services to the communities within their catchment area (Ngalande Banda and Walt, 1995; MoH, 2008).



The District Health Management Team (DHMT) runs the district health service. In many districts, the DHMT is based at the District Health Office located in the building of the district hospital. Sometimes this leads to confusion about the DHMT's wider role. The DHMT is responsible for the management of health care delivery in the whole district including those facilities not directly owned by government. It is therefore the responsibility of the DHMT to collaborate with various health care providers in the delivery of health care at district levels, including the negotiating of health care contracts with private health care providers like CHAM facilities (MoH, 2004; MoH, 2008).

## **2.6 CHAM development**

While the provision of health care services is shared between government and non-government providers, the non-government providers range from informal drug peddler to upper market private health providers and faith based organisations that are represented by CHAM and the Muslim Association of Malawi (MAM). CHAM is a not-for-profit umbrella organisation representing Christian mission hospitals while MAM represents all healthcare facilities operated by various Muslim organisations. While we recognise that health facilities represented by MAM play an important role in the health sector, the study will concentrate on CHAM due to the special relationship it has with the Malawi government.

CHAM evolved from the World Council of Churches committee in 1966. It was first named Private Hospital Association of Malawi (PHAM) and renamed CHAM in February 1992. It was established to help coordinate and strengthen medical development activities of Christian Mission hospitals. In addition to this, it was to act as a liaison between church health care provider institutions and the Government (MoH, 2004, 2008; CHAM, 2009).

Currently, CHAM represents 18 different church organisations that have 172 health care facilities of which 19 are hospitals, 22 community hospitals and 131 health centres. CHAM also supervises 10 Colleges that train nurses and other paramedics. The 10 training colleges are located in various CHAM hospitals around the country. Using these health care facilities, CHAM is accountable for 37% of health facilities nationally, 80% of these facilities are in rural areas and 76 out of 172 CHAM facilities have a SLA (HSSP, 2012).

The two main objectives of CHAM as outlined in its constitution are:

1. To improve communication and cooperation between its members and government
2. To improve the quality of healthcare service delivery

In recognition of CHAM's capacity to serve the national health sector objectives, the government has provided variable support to CHAM institutions over the years. Government financial support to CHAM dates back to the colonial era, whereby the government in its mandate to provide health care services to all the citizens provided subvention to hospitals run by missionaries. However, during the economic crisis of the 1970s and the political instability that followed the value of the subventions to CHAM institutions diminished greatly. Some CHAM institutions turned to local as well as international philanthropic and charitable organisations for support, while focusing less on pursuing subventions from government that diminished over time (MoH, 2004, 2008; CHAM, 2009).

From the early 1990s it became increasingly hard for CHAM institutions to cope with the cost of providing health care. This was due to a decline in financial flows into CHAM from charitable organisations and philanthropic organisations and also the government policy to increase civil servant salaries above the levels sustainable in CHAM institutions. This action caused an exodus of health care personnel, particularly nurses, from CHAM to government institutions. The initial response by CHAM institutions was to raise user fees in an effort to generate more revenue locally. However, this was unsuccessful because of poverty levels in CHAM institutions' catchment areas and protests by communities (Ngalande Banda and Simukonda, 1994).

Following the developments discussed above and to address the exodus of health workers from CHAM and escalating user fee, the Malawi government and CHAM signed a Memorandum of Understanding (MOU) as partners in health care delivery on 9<sup>th</sup> December, 2002, outlining the operating principles of a new partnership. Some of the operating principles are that CHAM institutions should continue charging '*minimum*' user fees, so that the poor people in the catchment area of CHAM institutions are able to access and utilise health care services. In return

the MoH will be responsible for paying salaries to all CHAM health care institutions' employees (MoH, 2004, 2008; CHAM, 2009).

Following from the MOU, CHAM is obliged to advocate and implement some government health policies. Some of the health policies that CHAM has helped advocate and implement include EHP, SWAp and SLA. It is the policy on the use of SLAs that the current study will focus on.

## **2.7 Overview of service level agreements (SLA)**

Service level agreements are health care delivery contracts between the government through local government and government district health offices, and private health care providers, in particular, CHAM facilities. In line with EHP and Program of Work I (POW I- 2004- 2010), the goal of SLA contracts was to improve equity of access to health care services for the poor in areas where there are no public facilities to provide health care services, but private providers exist but charge fees for access to services. This has been articulated clearly in Article two of the draft memoranda of understanding between the government and CHAM as follows (CHAM, 2009 and CHAM and NCA, 2009):

*“This Memorandum of Understanding is an agreement between the Malawi Government and CHAM. The overall objective of this agreement is to increase access to health service use by clients around CHAM facilities through the removal of user fees. This will be achieved through implementation of Service Level Agreements (SLAs) between the Government and CHAM which will make it possible for CHAM health facilities to offer some or the entire range of the essential health services for free to individuals within their catchment areas”.*

*The following shall therefore be the specific objectives of the SLAs*

- 1. To expand coverage of essential health services in a cost-effective and equitable manner*
- 2. To improve the quality of health services to populations within the catchment areas of CHAM facilities.” (Draft Memorandum of understanding between Government and CHAM, 2009)*

Originally, the SLAs were intended as a mechanism to fully implement the Essential Health Package (EHP). The first SLAs that were introduced in 2002 covered all EHP and other non EHP health care services. However, the current SLAs focus on neonatal and maternal health services.

Cost implications and staff shortages are the most important challenges in expanding SLAs to cover other elements of the EHP. This suggests that for the foreseeable future, SLAs will focus on neonatal and maternal health.

In the absence of a formal needs assessment, no final target number of SLAs has been set. However, DIP annual targets are used to monitor the number of SLAs. It is not the aim of DHMT and DHO to have SLAs with all private health care providers, rather SLAs should be established when there is a need for health services by the population in the area where the private provider is located. The need for SLA can be established based on the following criteria (MoH and CHAM, 2009):

1. Lack of option, thus there is no access to public health care facilities.
2. Lack of resources - there is government facility, but it lacks the necessary equipment and skilled medical staff;
3. Excess demand for the service in question beyond what the public facility can provide.

The SLAs replace user fees, thus removing the financial barriers for people to access and utilise neonatal and maternal health care services as well as reducing the financial risk associated with using health services. The funding for the SLA comes out of the District Health Office's (DHO) other recurrent transactions budget. The government does not provide extra funds for SLAs, as such, the District Health Management Team (DHMT) when preparing the District Implementation Plan (DIP) must adequately reflect the cost of administration, provision of service, monitoring and evaluating SLAs (CHAM, 2009 and CHAM and NCA, 2009).

Through the SLA mechanism, the Ministry of Health (MoH) covers the direct costs of medicines, medical supplies as well as monitoring of SLAs while CHAM facilities are responsible for indirect costs such as infrastructure, equipment and utilities. The SLA contractual fees that CHAM facilities charge have historically (when SLAs started) been arrived at by mutual consensus: DHOs would discuss with each CHAM facility separately to arrive at fees applicable to SLA. However, this has been replaced by standard costing and fees set by CHAM secretariat and MoH that are applicable in all SLA contracts.

As expected in any programme aimed at increasing access to services, implementation of the SLA programme has presented some challenges to both government and service providers. Some of these are: increased workload, shortage of personnel, shortage of drugs and equipment, congestion, increase in water and electricity bills and delays in payments by the District Health Office making it difficult for the contracted institutions to replenish depleted stocks of drugs and supplies (CHAM, 2009 and CHAM and NCA, 2009). These issues will be explored further in the results chapters of the thesis.

## **2.8 Conclusion**

This chapter has set the scene to both contracting out in the health sector in general and service level agreements (SLAs) in Malawi. Its particular concern is to present the overall changes in recent years in government funding of CHAM facilities through SLA, which has been subject to greater focus by major health sector development partners.

The first section has elaborated on the development of the modern health care system, health care financing, health care delivery system and the involvement of the private sector in health care provision. The second section has discussed major health sector policies that have shaped the health system in Malawi, the emergence of CHAM and its roles in the health system, and the service level agreement. The discussion shows that health care provision in Malawi has evolved over the years partly due to policies specifically to address health problems and as a response to changing macroeconomic factors in the country.

However, important to this study is the contractual relationship that has developed between CHAM and Ministry of health through SLA. The next chapter will therefore present a literature review on contracting out in general and its application in the health sector and discuss some economic theories that have informed contracting out.

## Chapter 3: Theory and experience of contracting out

### 3.0 Introduction

This chapter reviews the literature on contracting out, more specifically principal agent and transaction cost economics theories, as conceptual frameworks to shed light on and provide a better understanding of how government agencies, CHAM and development partners interact. Relevant published papers, text books and reports were reviewed and are discussed here with the above aim as a backdrop.

The literature review involved: consulting economics text books and published papers; following up relevant materials in textbooks and journal articles reviewed; consulting with experts in the field; and consulting some internet website resources (World Bank, World Health Organization, Centre for Disease Control and DFID).

Following the review of the main concepts of principal agent and transaction cost economics theories, the last section of the chapter presents evidence from empirical studies of contracting out in the health sector in both high and low income countries.

### 3.1 Contracting out in general

Contracting out has been widely used by both public and private sector agencies to procure a wide range of services, including cleaning, refuse collection, transport and fire protection. However, in the context of public sector agencies, the general theoretical framework for contracting out is based on government failure, a concept model of why governments fail in the provision of services (Mills and Broomberg, 1996). In general, Taylor (2003) has defined contracting as:

*“Contracting can be defined as a purchasing mechanism that is used to acquire a specified service, of a defined quantity and quality, at an agreed-on price, from a specific provider, for a specified period”.*(Taylor, 2003 p158)

Contracting out implies an on-going exchange relationship, supported by a contractual agreement. It involves a situation where one organisation contracts with another for the provision

of a particular good or service. It is essentially a form of procurement – the purchase of a service which could otherwise be produced in house by the purchaser. From the literature, the term contracting out has been used interchangeably with the term outsourcing and procurement (Palmer, 2006; Chalkley, 2006; England, 2004; Duran and McNutt, 2010). Contracting out is a common and growing phenomenon in both the public and private sectors (Bernard and Antisthenis, 2003).

Contracting out has thus become an increasingly important feature of purchaser provider relations in many countries, for example United Kingdom, United States of America, Brazil, Australia, Thailand and South Africa (Figuera et al., 2005; Ashton, 1998; Bartlett, 1991; Palmer, 2000 ; Chalkley, 2006). According to Macneil (1978), the theory of contracting is based on historical evolution from a single entrepreneur business, to a multi- disciplinary and specialised industrial economy which depends on multiple skills and broader scope of action. That is, an organisation chooses to contract another organisation for reasons of costs and expertise. The contracting organisation may decide that it lacks the expertise or resources required to produce a good or service and that the cost of hiring or developing that expertise in-house exceeds the costs associated with contracting for the expertise. Macneil (1978) outlined the roots and key dimensions of contracting arrangements in economic transactions and argued that contracting is a result of the necessity to society to plan for future consumption, a situation that elevated the use of promises instead of on-the-spot exchange (or ‘spot transaction’).

While contracting out for health and social services has not been common, private sector providers, particularly not for profit providers, have played an important role in the delivery of health, child care and welfare services. In the health sector governments have historically made considerable use of contracting out for non- medical health services such as food, laundry and transport. However, in recent years there has been a widening of the scope of contracting out undertaken in the health sector. There are currently several instances of governments in various countries contracting out directly with the private health care sector for the provision of core medical services (Figuera et al. 2005).

Contracting out health care services to private health care providers is often a component of reform packages promoted by bilateral and multilateral agencies for low income countries where the private sector is increasingly perceived as an important and often better resourced and

organised provider of health services. The motivation for contracting private health providers is twofold: first to utilise the resources these private providers hold and second to improve the efficiency of publicly funded services (Palmer, 2000). Ashton (1998) and Bartlett (1991) have argued that the introduction of contracts in health care may not enhance efficiency due to the increase in transaction costs that it implies.

Experience has revealed a number technical difficulty in implementing contracting in health care (Walshe and Smith, 2006). It has also been stated that, although contracts are in place in many health care systems today, they suffer from a number of limitations (Chalkley and Malcomson, 2000) among these limitations include that it is more expensive than traditional procurement mechanisms, as it introduces new categories of cost such as; the cost of awarding, managing and monitoring the contracts as well as fostering corruption and loss of government accountability and control. Similarly, several commentators (Clingermayer and Feiock, 1997; Boadway et al.2004; Boardman and Hewitt, 2004; Brown and Potoski, 2005) have identified the transaction costs incurred through contracting out. Furthermore, Light (1997) has argued that, a range of new inefficiencies that are brought by contracting, such as public health care managers spending considerable time monitoring, managing and maintaining contracts, disruption of essential services and ethos of commercialism replacing ethos of service as well as recruitment of full time contract managers. While the arguments of Light (1997) on new inefficiencies introduced by contacting may apply in some cases, this is not necessarily true for all cases of contracting. Inefficiencies as illustrated by Light (1997) will very much depend on a number of factors including: the type of service, contracting skills of those involved, institutions supporting the contacting arrangement and the management of incentives within the contract.

Despite the increase in the use of contracting out mechanisms, little is known about the nature of many contractual arrangements. Emerging evidence from health systems in low income countries suggests that contractual agreements are different in practice to the ones that were originally envisaged, with competitive contracts disappearing and being replaced by mutually dependent relationships. McPake and Hongoro (1995) have defined contracting as a normal market exchange of services which is formalised in advance by the issuing of a contract binding the buyer and seller to the conditions of the exchange. Thus, the contractual agreement spells out a



set of specific actions to which parties to a contract must comply. The contracting parties make reciprocal commitments - in essence a bilateral coordination agreement. The contracting or exchange objective in any transaction is to arrive at a mutually satisfactory outcome, an equilibrium point. This suggests that if parties are able to bargain together effectively and can effectively implement and enforce decisions, the outcomes of a contracting relationship will tend to be efficient, at least to the parties to the bargain (Milgrom and Roberts, 1992; Duran and McNutt, 2010).

In low income countries contracting out of health care services to private health care providers is often seen as one of the feasible solution to gaps in coverage, especially in areas where government health care provision is inadequate and there are already private health care providers practising. The kinds of contractual arrangements found in these low income countries differ slightly from the ones described by McPake and Hongoro (1995) in that they do not strictly contain mechanisms such as financial incentives and penalties and the ultimate possibility of termination, which can be used to steer the provider in the direction required or move to an alternative supplier (Walshe and Smith, 2006). This is particularly so due to the monopolistic/monopsonistic nature of the actors involved in contracting. Thus, there are no alternative suppliers/purchasers in the market, such that the threat of termination is hollow. For instance, if the state has been providing a public service for a considerable period of time, private sector organisations rarely have the knowledge or the expertise to carry out such activities (Sclar, 2000). The probable lack of established private sector actors to undertake such activities means that, before involving private providers, competition needs to be explicitly considered when governments are making contracting decisions (Williamson, 1986; Sclar, 2000; Hewitt, 2004; Duran and McNutt, 2010).

Palmer (2000) and Allen (2002) have argued that comprehensive contracting, with full specification of goods or services, is difficult to operationalise in the health care sector due to difficulty of measurement of some complex health care services and their quality attributes. This is argued to have necessitated the evolution of more relational contracting mechanisms whereby trust and mutual dependence replace the need to resort to the legal resolution of conflict. Macneil (1978) has also observed that most economic transactions are organised on the basis of relational

contracts. Preker, Harding and Travis (2000) have argued that health care service provision is complex as it has many tasks, some more measurable than others require team action rather than individual effort and may require more attention to quality than speed of production.

Palmer (2000) has shown that contractual arrangements in the provision of services are favoured under the following assumptions:

- Increased provider competition may increase technical efficiency on the supply side and therefore promote allocative efficiency within the system.
- Contractual relationships enhance efficiency on the purchaser and provider side via the incentive structure inherent in the contract.
- The contracting process itself may promote transparency in trading and decentralisation of managerial responsibility, both of which may have beneficial effects for efficiency.

These assumptions are clearly rooted in the neoclassical microeconomic theories which assume that all economic agents are rational and have perfect information<sup>3</sup> which they will use to make informed decisions about the best product, unbounded rationality and absence of opportunism. The applicability of these assumptions in health service delivery is questionable. Attempts to translate these assumptions in practice have highlighted some gaps particularly that:

- There may not be sufficient potential providers to create provider competition
- Provider competition without any change on the purchasing side, may not enhance efficiency
- The benefits of introducing market incentives may not outweigh the cost of their implementation and maintenance
- Government may not have adequate capacity to enter into and manage contractual relationships with private health care providers.

There are two main complementary theories that are most often referred to in relation to contracting out of health care services. These theories are listed below and explored further:

1. Transaction cost theory (Williamson, 1975, 1985)
2. Principal Agent theory (Ross, 1973; Jensen and Meckling, 1976)

The general definition of a contract is fairly similar in both principal agent model and transaction cost economics. The important difference concerns the assumptions made in relation to the degree of completeness of the contract (Brousseau and Glachant, 2002). The principal agent model assumes completely specified contracts whereas transaction cost economics relies on the

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<sup>3</sup> Perfect information practically means that all consumers know all things about the product at all times therefore makes the best decision about them (Williamson, 1975, 1985)

assumption of incomplete contracts, a distinction which is closely tied up with institutional assumptions. Under complete contracts, the courts can resolve disputes whereas incomplete contracts usually rely on private ordering<sup>4</sup>. In a private ordering scenario, decision making entails respond to adaptive and sequential decision making for information sharing, cooperation, dispute resolution or other interactions not formally dictated by the law (Bech and Pedersen, 2005). The subsequent sections will discuss principal agent and transaction cost economics theories.

### **3.2 Transaction cost theory**

Transaction cost theory is based on two behavioural assumptions. First, it operates on the assumption of bounded rationality, which refers to how the cognitive limitations of the human mind rule out a complete evaluation of the consequences of all possible decisions (Williamson, 1975, 1985). In a contracting out context, the impact of bounded rationality depends in part on the knowledge and skills the parties to the contract can draw on in specifying requirements, selecting appropriate contract partners and managing as well as controlling the relationship. Second, the theory operates under the assumption of opportunism, which posits that people do not only act in self-interest, but that they also act with guile. For instance, health care service providers may lie about or exaggerate their capabilities or use their knowledge advantage to enter into an advantageous service level agreement with local DHOs that have little experience and /or knowledge about market prices, outcomes of intervention and the incentives of private providers. Similarly, despite a clear Ministry of Health policy that DHO can enter into SLA contracts with CHAM facilities in areas where there are no public health facilities, some DHO may chose to concentrate on public health facilities. The providers and DHOs as illustrated here may do so because they want to advance their own interests.

Williamson (1975, 1985) has argued that if bounded rationality and opportunism were non-existent, all economic activities could be efficiently organised and that the presence of the two means that all contracts are incomplete. Complete contracts are those where every possible future contingency and potential actions to be taken by both parties to the transaction (should any of the contingencies occur) are specified. However, evidence has shown that the existence of complete

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<sup>4</sup> A process of setting up of social norms by parties involved in a regulated activity( in some manner), and not by the state

contracts is not possible in an environment characterised by uncertainty, complexity and bounded rationality since it is difficult to determine their terms (Duran and McNutt, 2010; Douma and Schreuder, 2002).

**Table 3.1: Contractual challenges due to opportunism and bounded rationality**

		<b>Bounded rationality</b>	
		<b>Absent</b>	<b>Admitted</b>
<b>Opportunism</b>	<b>Absent</b>	(a) Bliss	(b) General clause contracting
	<b>Admitted</b>	(c) Comprehensive contracting	(d) Serious contractual difficulties

Source: Williamson 1985

The foregoing implies that, designing long-term contracts is difficult due to bounded rationality and opportunism. According to William (1985), when analysing the mechanism of long-term contracts, four cases can be discerned, in three of which contractual difficulties do not arise as illustrated in Table 3.1.

The four cases as captured in table 3.1 can be described in the following way.

- a) Bliss- a contractual relationship with unbounded rationality and non-opportunism. A binding contract and effective communication occur, at least theoretically, between a principal and agent in the absence of bounded rationality and opportunism.
- b) General clause contracting- A contractual relationship with non-opportunism but there is bounded rationality. In this context contracting work well because of general protection clause contract, thus the parties undertake to reveal all relevant information and cooperate throughout the execution and renewal of the contract.
- c) Comprehensive contracting- a contractual relationship in which there is unbounded rationality, but opportunism is present. In this case contracts can be made to work well by recourse to comprehensive contracting. These kinds of contracts are referred to as comprehensive or complete contracts and foresee all possible opportunistic actions and

their consequences for both parties. However, as Williamson (1985) has demonstrated, complete contracts are not feasible owing to bounded rationality and impossibility of predicting all possible circumstances.

- d) Serious contractual difficulties- These are contractual relations in which there are both bounded rationality and opportunism. According to Williamson (1985), this case corresponds with reality, especially in contracts associated with natural monopolies and a monopsony market, and is characterised by the occurrence of all complex problems involved in contracting.

Incomplete contracts according to Williamson (1975) would not be a problem if parties to the transaction were not engaged in opportunistic behaviour. Williamson has further shown that individuals in the context of information asymmetries can be opportunistic when they use information to their own advantage in economic exchange. Ex ante opportunistic behaviour arises during the negotiation of a contract in circumstances where the parties to a transaction have different levels of information and they use it to their advantage. The provider, for example, may pretend to place a high valuation or the purchaser may pretend to place a lower valuation. On the contrary, ex post opportunism arises after the contractual agreement and may result in “reneging”, as one or both parties to the contract try to exploit loopholes in the incompletely specified contract.

### **3.2.1 Asset specificity and hold-up**

Asset specificity is a vital reason why contracting out of some services may become uncompetitive. Boardman and Hewitt (2004) have shown that provision of services that require large specialised investments that cannot easily adapt to other uses are likely to have few suppliers/providers. The problem is further complicated when the state is the only buyer of such services. In such settings, organisations cannot acquire necessary business by selling their services elsewhere. Williamson (1983) points out that specialised investment might include the following:

- The use of highly specialised human skill that cannot be put to work for other purposes
- The use of specialised equipment or a complex system for a particular purpose
- The use of a specific location that is only changeable at a huge cost

Williamson (1985 and 1986) defines transaction-specific assets as non-redeployable physical and human investments that are specialized and unique to a task. For example the production of health care services may require investment in specialized equipment and the existence of an uncommon set of professional know-how and skills.

Asset specificity widens contracting out risks in future rounds of contracting as the incumbent contractor has an inherent advantage in subsequent rounds as s/he has already made the required specialised investments necessary to deliver the service. Prospective rivals are unlikely to appear as they are not willing to make specialised investments if they are uncertain about winning the contract. Specialised investments act as an entry barrier in future rounds of contracting, creating monopolistic conditions in which the incumbent contractor can opportunistically exploit the contractee by reducing quality or increasing prices with little risk of penalty (Nelson and Winter, 1982; Walsh, 1995; England, 2004). In many circumstances this leads to limited competition among providers which leaves purchasers vulnerable to opportunistic behaviours like price gouging, an opportunistic behaviour designed to take advantage of unforeseen opportunity to charge a monopoly price, by threatening to withdrawal services or withhold output (Vining and Globeman (1999).

In its original conceptualisation, asset specificity is applied to the analysis of the purchaser-provider relation, where the purchaser is the party that does not own the specific asset and the provider is the party that owns the specific asset. Using this original conceptualisation of asset specificity, a hold-up problem may arise when the specific investment loses its value when the contractual relationship is terminated. In this instance, the hold-up is unilateral, thus the purchaser holds up the provider (Williamson, 1983). However, asset specificity could be bilateral, or even multi-lateral. For example Klein and Murphy (1988) noted that even in a traditional purchaser- provider relationship, hold up can be bilateral because the purchaser (the party that does not hold the specific assets) has exit cost associated with time and searching for an alternative provider if he decides to switch. Similarly, Vining and Globeman (1999) have pointed out that, the potential hold up problem exist for both parties, first, the purchasers risk contracting with providers that lock them into the relationship even given unsatisfactory performance.

Second, the provider may need to make large capital investment to provide services exclusively demanded by the purchaser.

### **3.2.2 Transaction costs**

The existence of specific assets can subsequently result in opportunism and increase transaction cost (England, 2004; Judge and Dooley, 2006). Ashton (1998) concluded that when transactions involve highly specific assets and are associated with considerable uncertainty and problems of measurement, contracts between purchasers and providers tend to be incomplete and therefore open to opportunism which may cause the contracting partners to incur transaction costs. Transaction cost should be differentiated conceptually from production cost, even though in practice this may be difficult (Ashton, 1998; Croxson, 2000). Transaction costs can be decomposed to motivation and coordination costs. Motivational costs mainly arise from opportunism and include the cost of motivating specialised agents to align their interest with the principal. Coordination costs are mainly due to bounded rationality and examples includes the cost of obtaining information, coordinating input in production and measurement (Stigler, 1961; Alchian and Demsetz, 1972; Barzel, 1982).

The ex ante transaction costs of contracting are those related to searching, drafting and negotiating a contract all of which aim to align incentives. The ex post transaction costs are related to monitoring, enforcing the contract and those that result from misaligned incentives. Even though the ex ante and ex post transaction costs occur in different parts of the process of transaction, they are not independent of each other. Croxson (2000) has argued that, an imprecise contract may have a lower ex ante transaction cost, but may lead to higher ex post cost, if there is a dispute over whether the contract has actually been breached.

Transaction costs are influenced by the nature of the transaction, the availability of alternative purchasers, the degree of uncertainty, the asset specificity of the non- trivial investment involved in the transaction, the degree of understanding of the transformation process from input to output, measurability / complexity of outputs, the mechanisms available to enforce contracts and the social context in which the transaction is embedded, especially the extent of opportunism and trust between the contracting agents (Williamson, 1985; Goddard et al., 2000; Preker et al.,

2000). Coase (1937) and Williamson (1975) have shown that there are no costless transactions as assumed by the neoclassical theory in real exchange. Thus, transaction costs are an obstacle to the efficient operation of private exchange, and if firms and market are alternative means by which to organise transactions, whichever is able to do so at least cost becomes the most desirable and efficient form of organisation.

### **3.2.3 Governance structure choice**

In order to protect the parties in the contractual relationship from opportunistic behaviour there is need to institute appropriate governance structures. The governance structure will regulate, provide direction, control procedures and provide an incentive system for the contract. The transaction costs literature (Ashton, 1998; Williamson, 1999; Croxson, 2000) outlines various governance mechanisms, i.e. different ways of coordinating economic activities: internal production through vertical integration and diversification, competitive markets and intermediate hybrid comprised of complex contractual arrangements. The governance structures as explained above provide various remedies for and protection against opportunism and uncertainty in an economic activity. Economic activities requiring investment in specific assets, in the context of strong information asymmetry and uncertainty justify the use of vertical integration (hierarchical) as opposed to market coordination because it allows transaction cost to be contained. This suggests that different types of transactions are handled under different governance mechanisms depending on their cost of production and transaction.

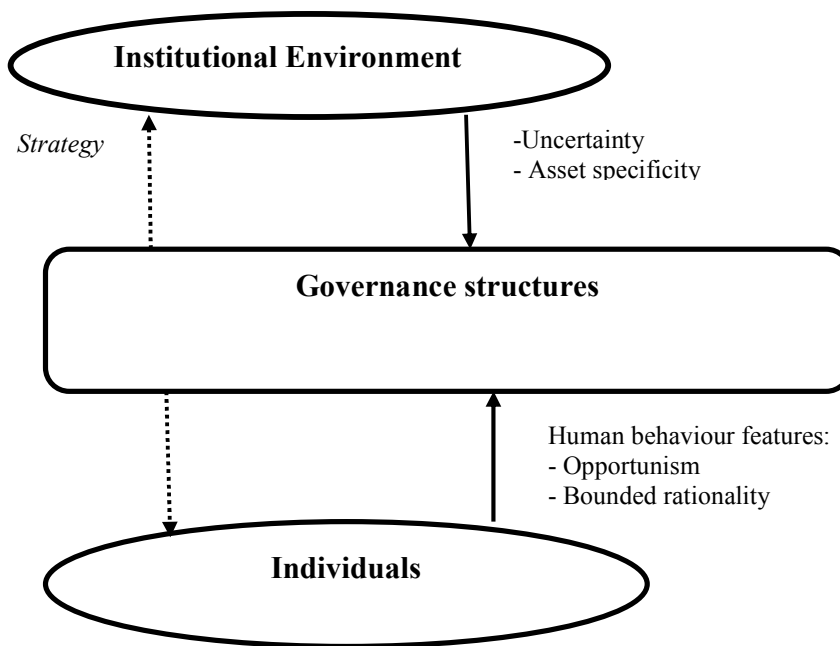
Transaction cost economics focus on contractual and institutional procedures (firms, hybrid forms and markets) and the category of costs which differs from production costs. The relationships between economic actors (principal and agent) are based on exchange, transactions which generate costs before the contract such as search costs of finding the right agent, costs incurred negotiating with the agent and costs incurred after the contract has been agreed to ensure that the activity has been carried out.

Williamson (1999) has stated that there are two factors that influence transaction costs and organizational choices as shown in figure 3.



- The institutional environment , which includes all fundamental legal, social and political rules that form the basis of production, exchange and distribution
- The coordination challenges linked to the characteristics of transactions which are determined by the interaction of human factors like bounded rationality and opportunism as well as the specificity of committed assets.

**Figure 3.1: Transaction cost economics**



Source: Adapted from Williamson 1999

Bounded rationality refers to the notion that economic agents will act rationally to a limited extent as they are constrained by future uncertainty and the complexity of problem solving. Williamson (1999) has stated that, *given bounded rationality, all contracts are unavoidably incomplete*. When there is opportunistic behaviour, economic agents act in their own interest at the expense of the other partner to the agreement. Alchian and Woodward (1988) has underlined two types of opportunistic behaviour; first, opportunistic behaviour linked to inability to observe the agent actions which may lead to moral hazard<sup>5</sup> problems. Second, opportunistic behaviour

<sup>5</sup> Moral hazard is present when a party to an agreement is not inclined to act on his promise because his actions cannot be observed by the other party.

linked to asset specificity particularly in situations where the contribution of each agent within the overall outcome is difficult to identify, and each party may try to appropriate a greater share of the benefit of the cooperation.

### **3.3 Principal Agency theory**

The second economic theory of interest is the principal agency theory. The theory postulates that a principal- agency relationship exists when two parties enter an agreement according to which the principal contracts an agent to perform a task on his/her behalf in exchange for a reward which generates utility, typically monetary compensation. The principal enters into such a relationship when s/he is not able or willing to perform the task him/herself. The agent possesses better knowledge and technical capacity in that specific field. The principal and agent enter into such a relation to gain utility (so out of self interest). The principal uses resources; in return the agent performs the agreed task (Chalkley, 2006).

In terms of economic analysis we recognise that the principal agent relationship signifies a contract (either explicit or implicit) and delegated decision making. The economic actor performing the task (usually called the agent) is doing so on behalf of or for the benefit of another economic actor (usually called the principal) who is then going to reward the agent (Chalkley, 2006). In a neoclassical economic model, the actors are assumed to be maximising their objectives with perfect foresight. They are aware of every state that could conceivably occur in the future and know the relative frequency of all states (Ross, 1973; Jensen and Meckling, 1976). This enables the parties to the contract to design a contract that incorporates all possible states and aligns incentives perfectly ex ante. Additionally, it is assumed that the parties will communicate their assessments of the environment costlessly, implying that negotiations and contract writing are costless. Due to the ex ante situation there is no need to be concerned with execution of the contract, and hence there are no ex post problems.

However, as explained in the transaction cost theory above, there is no costless transaction due to the presence of opportunism and bounded rationality. The major issue in principal agency theory is therefore to ensure that the agent acts in the interests of the principal. The theory would assume

that each party in the relationship has their own motives, because the parties' goals are not congruent. The principal cannot monitor the actions of the agent perfectly and without cost. Additionally, the existence of bounded rationality would limit the two parties from specifying all the different outcomes.

### 3.3.1 Information asymmetry

Asymmetric information in a principal agent relationship may give rise to moral hazard. Moral hazard is a special case of information asymmetry characterized by a situation in which a party to a contract when protected from a risk acts differently from how they would if they were fully exposed to the risk. In general, moral hazard is present when the party does not take full responsibility for its actions and tends to act less carefully leaving the other party to the contract to hold responsibility for the consequences of those actions. Generally, moral hazard takes place when the party with more information has an incentive to act inappropriately. Economic theory predicts that an agent, knowing more and better than the principal, is liable to moral hazard. Thus, the agent will have the incentive to do as little as possible to get his reward, knowing that the principal is not in a position to understand whether unsatisfactory outcomes can be ascribed to poor effort or simply bad luck and an unfavourable external environment. McDonald, (1984) has stated that;

*“The agent’s activities are known only to himself and there is no immediate incentive for him to reveal to the principal”.* (MacDonald, 1984 Page 415)

In a principal-agent model there is need to design incentives for the agent to exert the appropriate level of effort by linking his compensation to his performance. In a first-best world, with no information asymmetry, the principal would be able to evaluate the actions taken on their behalf by the agent and to practice control over the agent. However, in practice, the principal has a weak capacity to exercise such control as there is imperfect and asymmetric information. The agent's objectives do not coincide with those of the principal and enforcement is inadequate. This creates an opportunity for the agent to put less effort than the principal would wish (shirking) or divert some resources to its own ends (rent extraction) (Gauthier and Reinikka, 2007).

### **3.3.2 Multiple principal- agent relations**

Related to the problems of information asymmetry are the multiple principals and multiple agents when several entities are engaged in joint service delivery process. In the public sector, responsibilities are shared between several decision making levels following a central, zone and district. These levels are characterised by functional interdependence between levels. Action at one level has repercussion upon the effectiveness of the next level. This functional dependence between two agents creates problems associated with the difficulty of dissociating the individual contribution of the different agents at various levels (Holmstrom, 1982). In such cases, only aggregate or joint outcome would be measured, creating good environment for moral hazard as individuals are shielded from bearing all the cost of their actions due to difficulty of observing their private actions.

Generally this is the case for most contracts between government purchasers and private providers which involve the transmission of funds from a primary source to the health care provider. This transfer of fund introduces a complex set of principal-agent relations, which have the potential to bring conflict of interests and problem control in the contractual relation. For instance, a contractual relation could have principal 1 and principal 2. Principal 1 could be responsible for raising funds for the health system; in practice principal 1 is more likely to be a government agency. Principal 2 is the governing board at the providers' institution; the board is concerned with the management of the process to fund and control individual healthcare personnel. The ultimate agents are therefore the facilities operational managers and doctors. Following from the explanation above, the ultimate agent is an agent of at least two principals: the financing party and the facility board. This could be the very nature of the conflict. Principal 1 may seek to control via revenue system while principal 2 may control via the cost control and management system (Smith et al. 1997).

### **3.3.3 Principal-agent relations in healthcare**

Smith et al. 1997 have shown that the principal-agent model is found to be highly applicable in health care service provision, even though most analysis in healthcare has predominantly concentrated on the doctor-patient relationship. However, the issues raised in the doctor-patient

relationship are more relevant and applicable to the more managerial and political principal-agent relationships that exist at different levels of the health system.

While the concept of principal-agent relation has become widely accepted in health economics, there appears to be some lack of agreement about its precise role, how it operates and how it might be made to operate (Mooney and Ryan, 1993). Similarly, Evans (1984) has stated that, whilst the standard theory of agency, as it is applied to any market characterised by an asymmetry of information assumes that the principal's and agent's utility functions are independent, in health care it has been recognised that their utility functions are to a certain extent interdependent. Because of the complexity of health care and medicine, the information asymmetry between the purchaser and the provider in health care is more severe than in various other markets, for instance markets for consumer goods (Arrow, 1963).

#### **3.3.4 Extension to the standard principal-agent model**

Most analysis is based on one period non-cooperative situations; extension to this analysis will allow the construction of optimal reward systems through multi period analysis. In a multi period contractual situation, the principal through monitoring might acquire information about the agent's actions and incorporate this into the contract. If monitoring reveals extra information about the action of the agents, the fees schedule should depend on this information (Holmstrom, 1970). When contractual relations are considered in intertemporal models, which involve dynamic processes, the actions of the agents and the principal affect the evolution of an observable state. Similarly, literature on social learning shows that individuals observe one aspect or another of other individuals' behaviour to update their belief about the optimal course of action (Jehiel and Newman, 2011).

Jehiel and Newman (2011) further contend that principals, who are uncertain about feasible actions of their agents, get limited observations on earlier agent's behaviour and rationally update their beliefs about feasible actions. This suggests that when contracts are dynamic or continuous, principals who observed cheating in the previous contractual period close loopholes when they offer the next contract. This is linked to the literature on evolutionary economics which describes the evolution of contracts from complete, incomplete and relational.

### 3.4 Empirical research on contracting out health care services

Contracting out of health care services is widely used as an option in many settings, including in both high and low income countries. There is available evidence on the experiences in both middle and low income countries about contracting out of health care services, (Palmer et al. 2006; Mills et al. 2004; Soeters et al. 2006; Bennett, Russell and Mills, 1996; Lundberg, 2007; Liu, Hotchkiss and Bose, 2008). However, the evidence suggests that making a decision about contracting out the provision of health care services is not a straightforward undertaking and there is no recipe to follow (Mailly, 1986; Chalkley and Malcolmson, 2000; Allen, 2009). Generally, contracting out of services responds to a country's particular need at a particular period. Contracting decisions may then arise due to reasons including:

- The inability of public sector organizations to perform certain functions in-house (due to lack of capacity)
- Cost-efficiency motives, for instance to free up resources such as cash, skilled personnel, time and facilities for activities where the organization holds a competitive advantage.

Similarly, it has been stated that contracting out is not a solution to weak public sector management; rather it places new demands upon public health care managers, which, although distinct from direct health care provision, require management and supervisory skills (Abramson, 2001). In addition to this, a report by the African Development Bank has pointed out that:

*“Contracting-out practices are not intrinsically good or bad; it does not matter much whether agents are from the public, private or non-profit sector. Rather, what seems central is whether these contracted out services or functions can enable the state to strengthen its capacity and legitimacy overtime”*

(African Development Bank, 2009 page 4).

#### 3.4.1 High income country contracting out experience

There is an established literature on contracting out experiences in the UK particularly on reforms in the UK NHS and USA especially in the managed health care setting. These two sets of literature illustrate the potential benefits of contracting out, the remaining challenges in using health care contracts and the methodological difficulties in measuring performance, monitoring and evaluating the impact of contracts on health care in general.

In England, for instance, where general practitioners are contracted as primary health care providers, they consider themselves as private contractors with the freedom to maintain a contractual relationship with the public sector or to operate their private business. Regardless of changes that took place in the 1990s concerning the organization of group practices and the system of incentives and clinical performance, the fundamental idea of general practitioners as a contractor and not a salaried employee remains. This difference provides the understanding of the contracting out model.

Contracting out experiences in the UK NHS and USA managed health care are also illustrative in a number of ways. For example, contracts are being used for improvement in health care service quality and health care outcomes under managed health care in USA. In the UK NHS contracting out has been particularly driven by the central government strategy of improving quality and increasing efficiency in health care delivery in the period between 1990 and 1997. This was coupled with an increase of people employed in the NHS, and numbers went up through the 1990s and early 2000s, but have fallen since about 2006. The type of contracts varied from block contracts, cost per case contract to cost and volume contracts, but focused on performance targets and cost reduction (Mailly, 1986; Chalkley and Malcomson, 2000; Allen, 2009). Empirical work on contracting targets on waiting – time and average cost reduction have been documented during the NHS reforms (Chalkley and Malcomson, 2000; Chalkley, 2006). The contracting targets were set as a mechanism for improving hospital efficiency and controlling the rate of budget growth. Hospitals with higher average costs were given higher targets as opposed to those with low average costs. The performance of the hospitals was assessed by indicators such as the number of patients seen and the costs per patient case. The strategies adopted by the hospitals to attain the targets ranged from increasing outputs using the existing inputs and seeking higher discounts from suppliers, and cutting back on full time nursing staff.

These experiences indicate the potential impacts of contracting out health care services. The way providers responded was both positive and negative to the reform objectives. Evidence show that despite established institutional bases in both the UK and USA, measuring contracted services, establishing appropriate indicators and information systems remained a challenge (Saltman, 2002) and transaction costs for running the system were higher. Saltman (2002) has stated that:

*“As a result, the shift to a more entrepreneurial environment both within the public sector and beyond requires not only a similar level of state activity, but substantially more sophisticated types and levels of activity. This requires better trained and motivated personnel, better information, and greater financial and accounting expertise” (Kettle, 1993 in Saltman, 2002, Page 1682) “All of these, in turn, require considerable funding” (Saltman, 2002, Page 1682)*

After a decade of experimenting with contracting out of health care provision in the UK and USA health systems, performance indicators, measurement tools and institutional arrangements were still undergoing redesign in 2005 (Dawson, et al., 2005). The costs of implementing a more robust contractual arrangement, and evaluating systems were becoming a concern as well as the emergence of unintended effects (Smith, 1995; Saltman, 2002). In their report, Dawson et al., (2005) identified costs associated with behavioural changes that were emerging in response to contracting out.

These emerging responses could be analysed through the dynamic response hypothesis which explains the process by which context influences modify the innovations to create a difference between the intended interventions (de jure) and what the beneficiaries experience (de facto). The theory recognises that dynamic responses arise from the interaction of human agents in a particular context to determine the nature and form of the de facto intervention (McPake et al. 2006, Ssengooba et al., 2007). The intended structure and procedures that define the formal process are varied during implementation creating a different experience. At the core of the dynamic response theory is the role of informal actions, behaviour of human agents, constraints and relationships that evolve and explain the transformation between de jure and de facto interventions that may influence the health care system.

### **3.5.2 Low income country contracting out experience**

Formal contracting out of health care services experience in low income countries dates back to 1980s following the implementation of World Bank and IMF structural adjustment programs, which favoured partnerships between public and private health care systems; the experiences in the UK NHS in early 1980s and managed health care programs in the USA among others. While



the objectives of contracting out in high income countries have mostly focused on efficiency and performance measures, the rationale for contracting out in most low income are varied. Some of the rationales from low income countries' perspectives include:

- Adhering to loan conditionalities imposed on countries by international financing institutions. This is based mostly on new public management which criticises the traditional public structure and supports the introduction of market mechanisms that have the potential to improve public sector delivery of services (Hood, 1991).
- Addressing weak capacity in the public sector and extending coverage of services to under privileged populations, through contracting health services to non-state providers such as faith based organisations and NGOs that operate in the areas where under-privileged people reside (Bhushan et al., 2002).
- Stepping stone while addressing the lack of confidence in government, for example after a conflict (La Forgia et al., 2005).

The experience from contracting out in low income countries suggests that contracting has the potential to improve as well as worsen the delivery of health care services. Loevinsohn and Harding (2005) have pointed out that there are concerns that contracting out may not achieve the intended aims due to the following reasons:

- Contracts may not be able to cover large areas and make a difference at country level, as the government may not specify contracts to encourage delivery of health services to the most remote parts of the country.
- Contracting out could potentially be more expensive than state provision of the same services, due partly to large transaction costs, arising from bounded rationality, opportunism and asset specificity in contracts.
- Contracting could escalate the levels of inequities in healthcare services delivery, owing to the high concentration of private providers in urban areas, and the difficult to monitor the extent to which private providers extend services into all population groups.
- The public sector may have inadequate capacity to specify, manage and monitor contracts effectively. Cost are increased by hiring expatriate technical assistance both to help develop private and government capacity and strengthen contract management, for

instance, Palmer et al.(2006) has shown that an USAID funded contracting program had over 20 expatriates in Afghanistan

- Contracting out may not be sustainable, owing to the dependency of low income countries on development partners and multilateral agencies, to finance and provide technical assistance.

Experiences in Afghanistan ,South Africa, Rwanda, Zambia, Uganda (Palmer et al.2006; Mills et al.2004; Soeters et al. 2006; Bennett, Russell and Mills,1996 ; Lundberg,2007; Liu, Hotchkiss and Bose ,2008) as well as much cited examples of Cambodia (Soeters and Griffiths,2003 and Haiti (Eichler,2001), are indicative of the potential and challenge of contracting out in low income country settings (McPake and Ngalande Banda,1994; Mills,1995; Bennett, Russell and Mills,1996; Mills, Hongoro and Broomberg,1997; Loevinsohn and Harding, 2005). The experiences, especially in Rwanda and Zambia are relevant to Malawi's assessment given similar country settings (Palmer, 2000).

Due to the differences in the measures used and the incentive designs in these studies, it is difficult to compare contracting out schemes. Among the key features shared by most of these experiences is that they have been driven by external funding from donor agencies and are heavily reliant on external technical assistance. Most were started as pilot projects in situations that have marked shortages of personnel, infrastructure and medical supplies required in the provision of health care. This probably explains why most of them have targeted non-profit private providers such as church run health facilities and NGOs. Despite the similarities, there are differences in how the contracts are structured, performance measured and in the magnitude of effectiveness. The methods of evaluating effectiveness are themselves subject to methodological weakness which makes the effectiveness of these initiatives unclear for policy replication. These issues are briefly discussed below.

#### **3.5.2.1 Design of Contracts:**

Contract design entails writing contracts, specifying services, choosing providers and payment mechanisms as well as estimating costs. Contract designs in the contracting out of healthcare services are extremely diverse in terms of the type of purchasers and providers, contracts that are established and the objectives thereof (Mills and Broomberg, 1997).

Given the foregoing, contracts in Rwanda, South Africa and Zambia were designed differently. In Rwanda for instance, the country was just emerging from a conflict which had affected the capacity of the state to delivery health care. Contracts in Rwanda were therefore designed to address public sector capacity by delegating the provision of health care services to private providers under contracts. In 2001, the Rwandan government introduced Performance Based Financing (PBF) contracts with NGOs that were operating in the country, based on experiences from Cambodia (Mills, Hongoro and Broomberg, 1997).

In contrast, South Africa had a stronger public service as well as institutional arrangements that would support contracting out already in place including already established private health care providers operating in the country. South Africa provides a distinct pattern, having a long history of contracting out to both for-profit and not-for-profit health care providers as well as a wide range of services encompassing both clinical and non-clinical services (Bennett, Russell and Mills, 1996; Mills, Hongoro and Broomberg, 1997).

In Zambia contracting out of services to the private sector involved both private for-profit and private not-for-profit providers. Contracts were for the management of public health care facilities (hospitals) by private firms (delegated management). On the other hand, the Ministry of Health signed a memorandum of understanding with the Church Medical Association of Zambia in 1996 whereby hospitals and other health facilities under CHAZ would provide health care services (Perrot, 2006). The contractual relationship entailed that CHAZ hospitals would provide specified health services to a specific population and in turn the government would reimburse the health facility (Bennett, Russell and Mills, 1996).

The experience of South African contracts demonstrates that competitive bidding based on both the quality of technical proposal and price is feasible. The approach resulted in low cost for health care provision that can be sustained by the government (Palmer and Mill, 2003 and 2005). The experience in South Africa also highlights that contract bidding procedures must be clear to all parties involved; tenders should be clearly delineated and outside experts should be involved in the process of bid evaluation (Palmer and Mill, 2003 and 2005).

### **3.5.2.2 Performance measures**

Performance indicators in most cases were linked to health systems indicators: access, equity, quality and efficiency, supplemented by some management processes indicators such as performance audit, attendance of coordination or management meetings and patient satisfaction surveys. Proxy variables that were used in South Africa, Zambia and Rwanda include increases in the number of new users, the number of institutional deliveries, the percentage of fully vaccinated children and the contraceptive prevalence rate. However these input and process measures have been criticised for providing limited information on the effectiveness of a contracting out program. Similarly, it has been argued that the use of cost as a performance measure biases activity towards shorter and less intensive programs (Bennett et al., 1996; Mills et al., 1997; Meessen et al.2006; Perrot, 2006).

The capacity to successfully use and sustain a performance monitoring system was not adequate in Rwanda and Zambia, such that third party organisations were contracted to verify the performance of private providers. For instance the cost of monitoring performance through third party organisation was 11 percent of the contract cost in two remote districts. These performance measurement difficulties were prominent in Rwanda and Zambian contracts, and serve to demonstrate the problems of contracting out mechanisms especially in resource constrained settings (Meessen and Musango et al.2006; Perrot, 2006).

### **3.5.2.3 Institutional arrangements**

This section is concerned with countries' administrative and political legal frameworks supporting public sector contracting out of services to private providers. In South Africa such institutional arrangements were in place to enable contracts between government agencies and private sector healthcare providers. However, in Rwanda and Zambia temporary institutional arrangements which could not assure the sustainability of capacity were put in place. Such temporary arrangements included the use of foreign NGOs to perform institutional roles such as contract design, district health management functions and even service procurement in some cases. For instance a health centre management committee was put in place as the mechanism for monitoring the performance of health centre contracts in Rwanda (Meessen and Musango et al.2006). Other implementers of health care contracts took a hands off approach such that they

did not invest in institutional capacity strengthening activities (Bennett, Russell and Mills, 1996; Mills, Hongoro and Broomberg, 1997).

In Zambia, contracting out was part of a broad health sector reform that operated within a health sector decentralisation process. The aim of the contracts was to attain efficiency by creating competition among different health care providers. A body called the Central Board of Health (CBoH) was established and contracted by the Ministry of Health as the service provider. The CBoH in turn contracted out health care service provision to a network of providers, both public and private. Before the decentralisation process, the role of the private sector in the provision of health care services was generally relatively minor. Among the reasons cited for this is the lack of institutionalized policy instruments to foster interaction with the private sector (Meessen and Musango et al.2006; Perrot, 2006).

#### **3.5.2.4 Contracts effectiveness**

Effectiveness refers to the extent to which the contract improved access, equity, quality and efficiency. Based on these four measures, effectiveness has mostly been evaluated in relation to access, while less has been reported in relation to equity, quality and efficiency. For instance, in Rwanda, PBF contracts are said to have increased utilisation (OPD visits) by 80% on average, attended deliveries by 12-23% compared to 6-9% in provinces without PBF contracts (Meessen, Kashala et al.2007).

Just like Liu, Hotchkiss and Bose (2007) contracting out improved access to health care services, however the effects on other performance indicators like equity, quality and efficiency are reported less frequently. The context in which health care provision contracts are implemented and the design of the health care interventions are likely to influence the probability for success (Liu, Hotchkiss and Bose, 2007). In addition, Palmer et al, (2006) have shown that, in Afghanistan, contracting to NGOs has improved access. However, they have raised concerns on the quality of health care services provided, as well as actual and potential inequities owing to the distribution of NGOs in the country. Similar conclusions were made by Palmer and Mill (2005) when they looked at contracting out case studies in Southern African.

### **3.5.2.5 Attribution of access and utilisation**

Attribution of changes in access and utilisation to contracts is difficult. Changes could be more strongly related to other parallel programs and additional funding. For instance, in Zambia contracts were introduced in parallel with decentralization as well as other reforms, a situation which could lead to role confusion and conflict. Few studies examined in detail the ways that private sector providers responded internally to contracting out and the adjustments if any that were made, which better enable understanding of how changes in access and utilisation could be attributed.

The South African study demonstrated that private health care providers were highly successful in delivering services at a cost below that of public health facilities, particularly due to engaging fewer employees and promoting higher productivity (Bennett, Russell and Mills, 1996; Mills, Hongoro and Broomberg, 1997).

In Rwanda, PBF contracts were undertaken together with a move from out of pocket payment to third-party payment (insurance) that removed the financial barrier to seeking health care (Meessen et al.2007). These parallel interventions (more funding, better salaries for health workers, third-party payment mechanisms and reorganization of the public sector), coupled with contracting out may themselves be powerful and independent determinants of improvement in the performance indicators, thus confounding direct attribution of effectiveness to contracting out mechanisms(Rusa, Schneidman et al.2009). A concern has also been raised about weak evidence on the effectiveness of contracts. The concerns arise due to complex contractual design and complementary policy tools.

### **3.5.3 State of knowledge about contracting out**

From the review of the literature above, several key issues emerge regarding the mechanisms of contracting out in promoting access, utilisation, and quality; and in their implementation and the responses of health care providers. These are summarised below:

1. Although the agency theory provides the rationale for contracting out healthcare services, there are equally challenging prospects for operationalizing contracting out of health care services. Most of the challenges arise due to opportunism and bounded rationality which

ignite unintended consequences such as information distortion. Most researchers have recommended that this problem can be addressed through operational research that will track the intended and unintended consequences.

2. Although agency theory helps to explain why contracting out might work, transaction cost theory has been most useful in building explanations as to how bounded rationality and opportunism might change the behaviour of individuals in a contractual arrangement.
3. Theories of transaction cost economics and principal agency provide more proximal explanation about how individuals or organisations adjust their behaviours, which are embedded in social relations, norms and their history.
4. Although several contracting out pilots have been implemented and have been evaluated as successful, the institutional development required to support the scale up of such interventions has attracted contention in the literature. Some researchers recommend a “hands-off” approach while others invest in expensive and foreign technical assistance to play institutional roles such as design, implementation, monitoring and evaluation of the contracting out mechanism. From this perspective, upstream interventions to strengthen health system governance may need to be part of the package to make contracting out more feasible for policy action.
5. From an implementation perspective, the literature on principal agency and transaction cost economics suggests that contractual relationships involve adjustments and adaptations to historical precedents, contextual realities and new information generated during actual implementation. This perspective favours more process- oriented evaluations that track actions, challenges and adaptations during the implementation of contracting out. This helps to provide real time data to understand feedback loops to guide decisions about adaptation and adjustment.
6. Although the literature about effectiveness of contracting out is growing, the claims of effectiveness have not been matched by methodological rigor and attention to health system contexts. The attribution to change in access and quality has been entangled with the complexity of additional interventions in the health system. Most evaluations have not provided the causal pathway through which contracting out leads to changes in access and quality.

### 3.6 Conclusion

Even though there is growing interest and experience with contracting out the provision of health care services in low income countries, there is relatively little evidence on the impact of contracting out on efficiency. This is surprising given that the main rationale for interest in contracting out is its perceived potential for improved efficiency compared with public sector provision. Studies by Khan and Ahmed (2002) and Bloom et al. (2006) suggest that from the perspective of government, contracted private health care providers are either less efficient or more costly than public health care providers. In contrast, Cercone et al. (2005) found that contracted private health care providers were less costly than public health care providers. The results of Mills et al. (2004) and Daniel and LaForgia (2005) provided mixed conclusions. The results of Cercone et al. (2005) suggest that private health care providers achieved cost savings by reducing technological intensity of health care provided and the possibility of being penalized for non achievement of stipulated targets.

While the review of contracting out health care services suggest that contracting out has in some cases improved access to health care services, the effect on other health systems performance indicators such as equity, quality and efficiency are often unknown (Liu et al., 2008). Similarly, less is known of the system wide effects of contracting out health care service, which could be either positive or negative (Liu et al., 2008).



## **Chapter 4: Analytical framework and Methodology**

### **4.0 Introduction**

This chapter will present the analytical framework and its formalisation, and the methods that were used in the study. The analytical framework outlines the interaction between a principal and agent in an environment characterised by opportunism, bounded rationality as well as by external factors. The framework is followed by an economic formalisation of the relationship between the principal and agents to highlight some economic assumptions that have not been reflected in the analytical framework. The later part of the chapter will discuss the aims, objectives and methods of the study.

### **4.1 Analytical framework**

Principal/agency theory explains why the purchaser (e.g. MoH) and the provider (e.g. CHAM institutions) seek a contractual relationship (governed by the SLA) to provide health care services as illustrated in figure 4.1. In the contractual relationship, CHAM institutions provide maternal and child health care services as well as comprehensive health care services in cases where the facility is designated a district or referral hospital, and the Ministry of Health in turn reimburses CHAM institutions. In this relationship the purchaser has objectives s/he seeks to maximise. They may be related to the type of service i.e. essential health services or a subset of these services, as in the case of child and maternal health in the SLA. On the side of the providers, CHAM institutions' objectives may or may not be related to Ministry of Health objectives. For example, availability of budget excess among a number of faith based institutions may attest to the possibility of a profit objective (Reinikka and Svensson, 2003). Although most CHAM institutions impose user charges, the charges are not in excess of costs. They receive government subsidies, tax exemptions and charitable donations on the basis of a social objective of serving the poor and underprivileged (Hanson and Berman, 1998; Hanson et al. 2008). As fundamental to the principal/ agency problem, the Ministry of Health has limited information about the costs and efficiency with which resources are used in CHAM institutions. Objective functions, both stated and revealed will be explored further in chapter 6 which considers various objective functions of

public sector agencies and not for profit private organisations in general, as well as those specific to the Ministry of Health and CHAM institutions.

In a situation of information asymmetries and objectives to maximise utility, principal/agency theory suggests that the principal/purchaser (MoH) should align incentives to ensure that his/her set of objectives is met. However, incentive alignment is costly in any contractual relationship including the health care industry (Preker et al. 2000). The recourse to the agent/provider (CHAM institution) could be understood as a lever to drive maternal and child health care provision to a higher level of performance. In the case of limited purchaser information on the internal cost structure and efficiency level of CHAM institutions, SLA payments represent both a minimum profit (incentive) to the institution that the purchaser (MoH) is prepared to allow the reimbursement of added costs that might arise in securing higher service targets.

The minimum payment made by the principal to the agent as discussed here can be understood through the concepts of marginal or opportunity cost and the minimum supply price in economic theory. Economic theory predicts that providers or suppliers of services/goods will supply when price covers the increase in total costs, or marginal cost of producing an additional unit of the service. Producer's surplus is defined as the difference between what the producer receives and the producer's minimum supply price. The producer's surplus or minimum payment is therefore one of the key factors that can explain the response of the private health care provider to SLA payments.

The response to the SLA payments is further influenced by the governance relationships in the provider's hierarchy that involves boards of governors (Dib et al., 1998), hospital managers and clinical staff. SLA payments by the DHO are made to CHAM institutions where administrators and clinical staff will make decisions regarding strategies to attain targets and how to allocate SLA funds. The framework suggests that the contractual relations are open to influences from other factors at the same time i.e. the external environment within the health sector such as the market for provision of services and governance structures in both the purchaser and provider organisation. The main components of the analytical framework and how they may influence the outcome of the contractual relationship are illustrated in figure 4.1 and briefly explained below.

**Figure 4.1 Conceptual frameworks for contracting out**

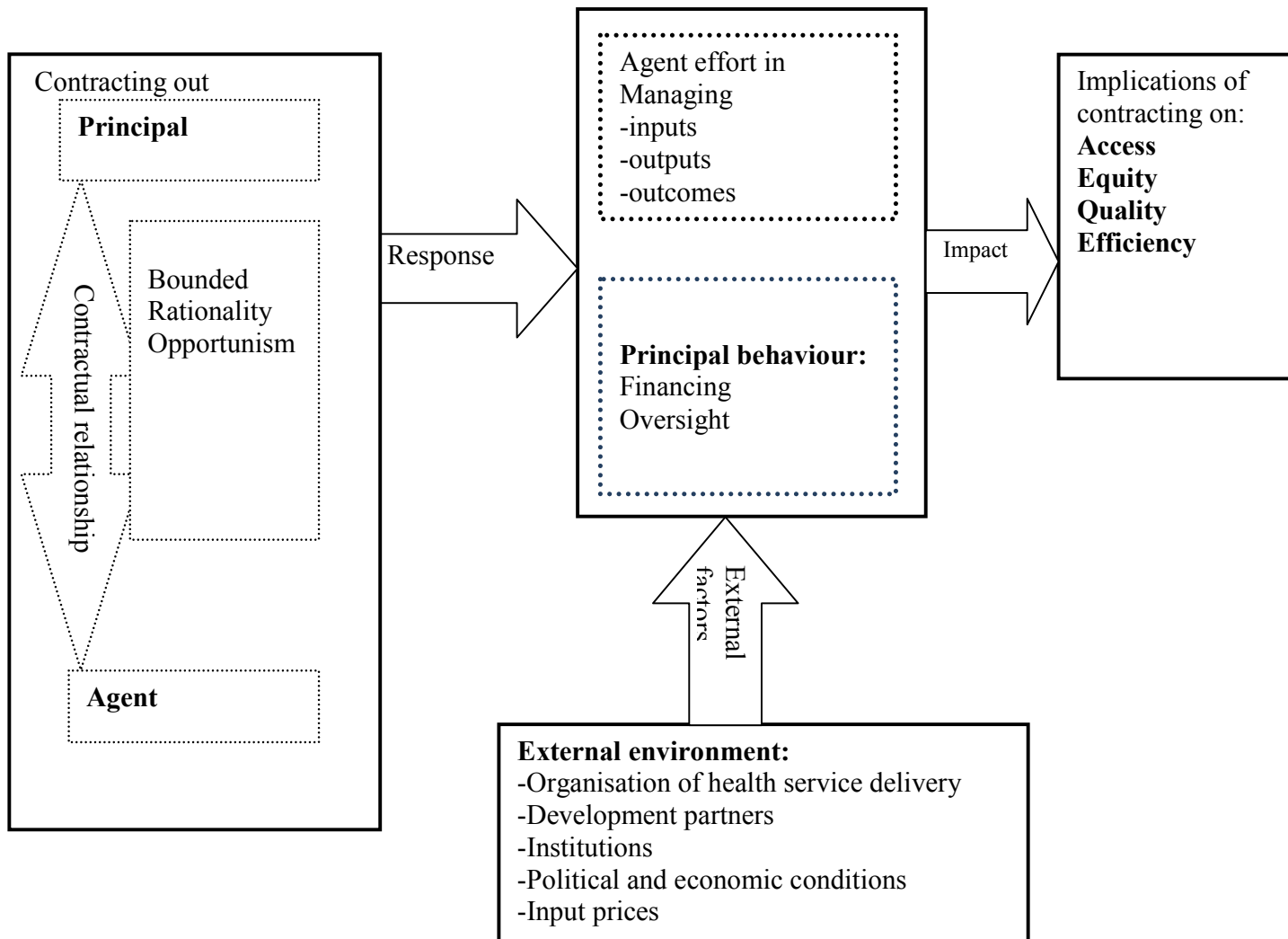


Figure 4.1 A conceptual framework for contracting out, Adapted from Liu et al.2007

#### 4.1.1 Contractual relationship

As illustrated in figure 4.1 the principal and agent are involved in a contractual relationship. The principal serves as a government purchaser, whose main functions in the contracting out arrangement are financing and oversight, with the overall objective of improving access, equity,

quality and efficiency of health care services (Liu et al, 2007). The agent/ health care provider is the other party in the contracting out relationship. The agent can either be private-for-profit, or private non-profit (NGO). In this study the agent is a not-for-profit private provider. The agent's function in the contractual relationship is to provide health care services as stipulated in the contract.

#### **4.1.2 Response**

The responses of the principal /purchaser and agent /provider will be influenced by the level of opportunism and bounded rationality on the part of either party to the contract. Responses will be reflected in the management of inputs, outputs, outcomes and systems performance. However, the impact of the contractual relationship is a sum of the responses to contractual factors as well as external factors. Hence, the way the principal and agent will respond given bounded rationality, opportunism and external environmental factors will determine the impact of the contractual arrangements on access, equity, quality and efficiency in the provision of health care services (Liu et al., 2007).

#### **4.1.3 The external environment**

The external environment entails among other factors the characteristics of the health care sector, institutional arrangements, financial sector and the political state of the country. These factors make up the environment surrounding the contracting out of health care services. While most of these external factors are unlikely to influence health sector policy in the short run, they can potentially be key determinants of the success or failure of a contractual relationship to achieve its objective of improving access, equity, quality and efficiency in the long term.

For instance, legal, regulatory and financial systems are among the key components of a contractual relationship. In situations where the legal system is weak, contractual agreements between principal and agents are less likely to be binding, reducing the potency of the contract. Similarly, lack of functioning regulatory mechanisms can influence the state's ability to both monitor the action of the health care providers and to place sanctions on them if they are not meeting minimum standards. In addition, the absence of a sophisticated financial system may potentially affect financial audit and accountability of contracting out mechanisms. The foregoing

suggests that weak institutions, financial systems and political structure together provide an opportunity for corruption and may impede contract effectiveness.

Regardless of the particular indicator chosen, observed outcome levels will be a product of joint influences of contract related factors as well as factors outside the influence of the contract, such as the levels of competition in the providers market, political environment and other unspecifiable factors. Measuring the contribution of contracting out to access, equity, quality and efficiency requires being able to apportion the relative contributions of contracting related factors and those not related to the contract.

#### 4.1.4 Impact on health system performance indicators

Relevant to government health policy makers is the impact of contracting out on their objective of improving health system performance indicators: access, equity, quality and efficiency as identified by World Health Organisation (2000). Assessing the change in the four indicators is important in producing evidence on the effectiveness of contracting out. The impact of the contractual relationship on access, equity, quality and efficiency depends on how the principal and agent respond to factors within the contractual relationship as well as external factors. The responses of the agent and principal can be observed through the management of inputs, outputs, and outcome as well as measures taken by both parties to foster the contractual relationship.

- **Input management** refers to the agent's action to acquire and use inputs in order to achieve the contractual requirements as specified in the contract. Relevant inputs in the case of health care services include skilled health workers, medical supplies, medical equipment, essential drugs and infrastructure.
- **Output Management** refers to the actions of the agent to maximize health services output for achieving the contractual target e.g. utilisation, coverage and access with the available resources.
- **Outcome management** refers to the use of services to produce health and client satisfaction (i.e. selection of an efficient mix of health services from the perspective of health and client satisfaction outcomes).

A brief overview of the health system performance indicators as discussed above is presented next:

### **1- Access**

There are many definitions that have been put forward for the term access, the definition used here is that proposed by Schmidt (2007) which recognises that access can be understood as a combination of availability, accessibility and affordability. According to Schmidt (2007), availability compares the kind and quantity of health care services required by the client with what health care providers are providing, particularly with regard to human resources and medical facilities. Accessibility highlights the geographical factor focusing on the fact that distance can play a major role in preventing people from getting health care. Affordability compares the financial capacity of health care consumers with the cost of health care provided as reflected in user charges, insurance premiums and co-payments.

Access as defined above is consistent with Liu et al. (2007) who have stated that access is the presence or absence of barriers, financial and physical that people encounter in using health care services when needed. Financial barriers are usually those related to the out of pocket expenditure incurred in seeking and obtaining healthcare services. Physical barriers are related to the general supply side factors that affect the availability of health care services including distance to or travel time necessary to get to the health care facility, while cultural barriers relate to language, gender and ethnic grouping.

### **2- Quality**

Quality of health care is a contentious concept and there is no consensus on its definition (Friedman, 1995; Chalkley and Chalkley and Malcomson, 1997; Chalkley and McVicar, 2008). For instance, WHO's (2000) definition is that, "Quality is the process of meeting the needs and expectations of patients and health service staff", while the American Medical Association (1991) defines quality as the degree to which care services influence the probability of optimal patient outcomes. Given that defining quality in health care is not straight forward, Buetow and Roland (1999) have pointed out that,

*“Having been defined in many different ways, approaches to measuring and improving the quality of health care have become confusing, leading to misunderstandings and hindering efforts to improve care”*

(Buetow and Roland, 1999, Page 184)

However, Donabedian (1966) has stated that;

*“Criteria for quality are nothing more than value judgements that are applied to several aspects, properties, ingredients or dimensions of a process called medical care. As such, the definition of quality may be almost anything everyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is a part”.*

(Donabedian, 1966 page167)

Similarly, Arrow (1963) has stated that patients may simply not be aware of all aspects of the quality of health care services - some aspects of quality in healthcare can only be assessed in the process of actually receiving treatment and some not even then.

According to Donabedian (1966), quality has three dimensions; structure, process and outcome. Following from this description, quality measures in health care consist of three distinctive groups:-

- Structural indicators measuring the attributes of health care providers e.g. availability of specified inputs and services
- Process indicators e.g. compliance of health workers to clinical guidelines, whether referrals are made in compliance with recommended guidelines
- Outcome indicators – improvement in anthropometry, morbidity, mortality and responsiveness.

### **3- Equity**

There is no one accepted definition of equity in health. For instance, WHO has stated that, *“Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically”*;

Braveman (2006) points out that equity refers to the fairness in the distribution of health care access and outcomes across individuals or groups with different levels of socio economic status and Liu et al. (2007) have proposed that equity can be measured by comparing access and health care outcome indicators between socio-economic groups e.g. by income, location, gender and race.

The essential elements of the definitions and descriptions of equity proposed by WHO, Braveman (2006), Liu et al. (2007) and major health organisations are:

- Inequities are unfair, deviant and preventable differences in health status, in the distribution of disease and illness, and in mortality rates across the population
- They are outside the control of individuals, implying they are systematic problems. Although individual choice influence health, these patterns across population groups are not a result of individual's choices only
- They are generational and sustained over time , and are beyond the control of individuals

In addition to the definitional problem of equity as illustrated above, another contentious issue pertaining to equity is the overlap between equity and equality. These overlap and definition problems are covered extensively in the literature (Anderson and O'Neil, 2006; Zere et al., 2007; Green, 2008; CPRC, 2008; O'Meara, 2008; Jones, 2009). In this thesis, equality denote individuals with the same circumstances treated equally, while equity as defined earlier, imply that, individuals are treated fairly, but differently, having taken account their difference in circumstances.

An equally important dimension of equity is the difference between horizontal and vertical equity. Horizontal equity requires equals treated equally, for instance, individuals with the same income should be taxed at the same rate. Vertical equity requires unequal treatment of unequal to promote greater fairness, for instance, taxing high income groups at higher rates.

Another controversial issue in relation to equity is how to measure it. Braveman (2003) has argued that,



*“Because equity is a normative concept, one cannot directly measures equity in health or healthcare: However, one can measure inequalities in health between more and less advantaged social groups”* (Braveman, 2003, page 183).

Similarly, Reidpath and Allotey (2007) have indicated that, usually equity is measured using health inequalities- implicitly conflating equity and equality.

Despite the definitional controversies discussed here, England (2004) has stated that equity in health care provision could be improved by using three distinctive contracting out strategies:

- Contracting out arrangements that specifically encourage health care providers to serve the poor and underserved populations.
- Contracting with private health care providers in areas that are predominantly poor (geographical targeting)
- Contracting out services of most benefit to the poor and underserved.

#### **4- Efficiency**

Efficiency refers to the relationship between inputs and outputs. Technical efficiency involves the physical relationship between a given mix of inputs and outputs. A production process is technically efficient if it produces the maximum output possible (quantity of health care services and level of health care) with a given level and mix of physical inputs. The physical inputs include skilled and unskilled health workers, medical supplies, essential drugs and infrastructure. Allocative efficiency describes the relationship between input mix and outputs but also involves consideration of the prices of the input. Allocative efficiency therefore represents minimizing the amount or total cost of inputs while maximizing the benefit of output (Penner, 2004), or allocation across service type to maximize social welfare. This is achieved if the best input mix used is cheaper but produces more for the production of a given amount of output. These two types of efficiency can be affected by contracting out health care services (Taube, 1987; Hollingsworth, Dawson and Maniadakis, 1998; Palmer and Torgerson, 1999).

## 4.2 Formalization of the analytical framework

The relationship between the government and the private health care provider can be formalised by adapting the basic model presented by Laffont and Martimort (2002). The formalisation as presented here is a way of capturing some economic theory and assumptions that are not explicitly reflected in the analytical framework. We will assume that the objective function of the public purchaser depends positively on the quantity of health care services provided and negatively on the financial payment promised to the private provider. The frequency of the service depends mainly on the population parameters (age, sex, social class structure and general health variables) which vary relatively slowly and predictably. Before the provision of health care takes place, the agent makes an investment in effort ( $e$ ). For example, the agent chooses the staffing level for the wards, or invests in equipment which can be more or less technologically advanced, and more or less expensive. The cost of the effort is  $Q(e)$ , satisfying  $Q', Q'' > 0$ . The model also imposes innocuous conditions which avoid corner solutions:  $Q'(0) = 0$  and  $Q'(e_{Max}) = +\infty$  for some sufficiently high ( $e_{Max}$ ). Thus, when effort  $e$  is very low it is very cheap to improve it, and there is a physical maximum beyond which effort cannot be increased. We also assume that clients are identical: the benefits and costs of treatment are the same for every client. The quality of the service is not observable; while both principal and agent know the quality of the service, there are many facets of quality that are impossible to verify before the courts (Bos and De Fraja, 2002).

The quantity of health services provided can vary in relation to the effort ( $e$ ), made by the health care provider in the production process through managing inputs, outputs, and outcomes as well as performance monitoring and to the occurrence of a series of stochastic events that are neither foreseeable nor influenced by the contract. Stated formally, the quantity of health care service provision is a function of effort ( $e$ ) and some unobservable random variables (Stiglitz, 1989).

$$X = F(e, r) \quad \text{Where } X = S_- \text{ or } S^+$$

Where  $X$  is the quantity of health care service provided, in practice the quantity of health service to be provided is typically not known at the time the contract is made;  $e$  is the provider's effort

and  $r$  is a vector of unobservable exogenous random variables. Some of the elements in vector  $r$  are disease conditions, economic conditions and weather conditions.

It is clear that the service will be provided with a higher probability, for given stochastic events, the greater the effort the health care provider puts into its production and management. The objective function of the health care provider will depend positively on the net cash flow generated by providing the health care service minus costs to be borne directly, while it will depend negatively on the effort that will be made in provision of the health care service.

A risk neutral health care provider will be assumed, whose objective function may be simplified as follows:

$$U = t - \varphi(Q(e))$$

Where  $t$  is the payment made by the public purchaser,  $\varphi$  is a disutility depending on the cost of effort  $Q(e)$  made to the provision of health care services by the health care provider. We will consider the case where  $(e)$  may take only two values, 0 (zero effort) 1 (full effort), the function  $\varphi$  will be characterised by assuming a value of zero for a zero level of effort, and constant, equal to  $\varphi$  when  $e = 1$

$$(\varphi(0) = 0) - (\varphi(1) = \varphi)$$

The objective function of the public purchaser coincides with the social benefit deriving from the provision of health care services, net of the costs of health care provision (contract enforcement and others). Thus, the public sector purchaser (principal) cares about health care service provision and the price that they pay for the provision of care. We interpret service provision broadly and say that service has been provided if people needing the service have accessed it. For simplicity we will assume that the type of health care services provided may take only two values: no service provided  $S_-$  and service provided  $S^+$  whether service is provided or not depends on the health care provider's effort ( $e$ ) and on the occurrence of uncontrollable stochastic events as explained in the previous section above.

In any case, the result is always:

$$\begin{aligned} \text{Pro}(S = S^+ | e = 1) &= P \\ \text{Pro}(S = S^+ | e = 0) &= P \end{aligned}$$

Hence, for any given stochastic event, the probability that the service will be provided is greater if the health care provider makes an effort( $e$ ). The objective function of the public purchaser will therefore be:

$$V_1 = P(S^+ - t^+) + (1 - P)(S_- - t_-) \quad \text{If } e = 1$$

$$V_0 = P(S^+ - t^+) + (1 - P)(S_- - t_-) \quad \text{If } e = 0$$

Where  $t^+$  are payments made to the service provider for providing health care services and  $t_-$  is what the provider gets for not providing the service  $t_- = 0$ . Assuming that the principal can vary payments according to whether service is provided or not.

To induce the private provider to make effort, the government purchaser should draw up contracts having the following properties:

A contract that is accepted by the provider (contract of participation or individual rationality-IR), such that the utility expected by the private health care provider is greater than or the same as that obtainable without commitment (Incentive compatibility constraint- IC). The IC constraints are important here; because if they are not imposed the solution to the contractual relation might be economically meaningless, as it may produce outcomes that meet some criteria of optimality but which the provider (agent) would choose not to perform.

There are two potential variations on what has been presented above, symmetric information and asymmetric information. In a symmetric information situation, effort is perfectly observable, it is therefore not necessary to give any incentive to the private health care provider to make him provide the service and the financial payment can be constant with respect to the service provided. In this case the service provided will only be influenced by the stochastic factors which do not depend on the provider's will and commitment.

Formally, in the case of symmetric information due to moral hazard, the second constraint is not important and the public administrator must simply maximize  $V_1$  with respect to individual

rationality IR. The latter, assuming that the private provider has no profitable alternatives may be written as:

$$IR) p(t^{\wedge} - \varphi) + (1 - p)(t_{-} - \varphi) \geq 0$$

Clearly a rational health care provider will sign the contract to provide services if the expected utility is greater than or equal to that deriving from not signing it.

However, in a situation where there are information asymmetries, the effort of the health care provider is private information. At this point it is necessary for the public purchaser to incorporate an incentive compatibility constraint in the contract. The incentive compatibility constraint will induce the private provider to put the level of effort deemed optimal by the public purchaser. In this case the public purchaser will aim to maximize  $V_1$  with respect to  $IR$  and  $IC$  and this can be formalised as follows:

$$IC) p(t^{\wedge} - \varphi) + (1 - p)(t_{-} - \varphi) \geq qt^{\wedge} + (1 - q)t_{-}$$

The solution is provided by the levels of  $t_{-}$  and  $t^{\wedge}$  that satisfy the two constraints  $IR$  and  $IC$ . solving the algebraic equation above for the two unknowns yields:

$$\begin{aligned} t^{\wedge} &= (1 - q)\varphi/(p - q) > 0 \\ t_{-} &= -q\varphi/(p - q) < 0 \end{aligned}$$

The private health care provider's effort can be obtained by means of a payment mechanism that rewards the provision of health care services and punishes the non-provision of health care services. In this case the problem of moral hazard is of no practical importance and does not produce any inefficiency.

The description of the analytical frame and its formalisation helps to answer two important questions related to the possibility of SLA improving access, equity, quality and efficiency and how this will be achieved. The two questions are posed here and explored to provide a pathway through which SLA can affect the four factors.

#### **4.2.1 Will SLA improve access, equity, quality and efficiency?**

SLA may or may not increase access, equity, quality and efficiency in health care services. Principal-agent theory predicts that agents (healthcare providers) would provide health care services under SLA if the contract provides sufficient revenue to meet their reservation utility or cover the marginal costs of producing other health care services- put differently, if the financial payment is worth the cost of effort. If the marginal cost of effort in providing the service is deemed to be worth the financial payment, economic rationality would commit the agent to provide health care services subject to the exogenous factors explained in the previous section.

Transaction cost economics suggests alternative approaches to the question. Since the parties to the contractual relationship are subject to bounded rationality and opportunism. They may not be able to specify and foresee other factors that might affect the contractual relationship which may include: increase in costs, staff migration and parties behaving opportunistically. Thus, unlike the principal-agent model, transaction cost economics explains the behavioural factors that can potentially influence the parties to the contract and impact on the contractual arrangement as well as outcomes.

#### **4.2.2 How will SLA improve access, equity, quality and efficiency?**

Following from the analytical framework and economic formalisation of the analytical framework as well as the definition implied in the specification of SLA, the provision of health care services through private healthcare providers will improve access, equity, quality and efficiency when elements related to bounded rationality, opportunism and information asymmetry as well as factors outside the contractual relationship such as institutions and politics are taken care of.

### **4.3 Study propositions – Complementary theories**

The study uses 2 propositions as theoretical guides for constructing explanations of the implications of SLA on access, equity, quality and efficiency. In this regard, propositions are not hypotheses to be tested in this study but serve as a guide for evaluating and interpreting findings and structuring the policy implications thereof. Each theory explained in the literature review offers a proposition:

**Proposition 1:** The principal- agent theory will be sufficient to explain the actions of public agents and private health care providers in the SLA contractual relationship. The actions of the two parties to the contract will exhibit the following:

- Economic interest of the parties to the contract will determine the provision and availability of health care services
- The provision of healthcare service by the private provider will be sufficiently explained by the size of financial payment that they get i.e. more services will be provided if higher payments are made by government

**Proposition 2:** Transaction cost economics will be sufficient to explain how the presence of bounded rationality and opportunism impinge or facilitate the provision of health care. The contracts will exhibit the following:

- Renegotiation of the contracts ex-post
- Hold-up problems due to low provider competition and lack of substitutes

## **4.4 Aim and Objectives of the study**

### **4.4.1 Aim of the study**

The broad aim of the study was to evaluate the implications of SLA contracts on access to health services, equity in accessing health services, quality of health care and efficiency in the provision of health services at CHAM institutions and to identify factors likely to affect their success or failure. Two complementary theoretical frameworks of principal- agent model and transaction cost economics are used to explain the process and difficulties of contracting out, and arrive at policy recommendations.

### **4.4.2 General objective**

- 1: Describe CHAM facilities responses to SLA payments under the contracting out mechanism.
- 2: Assess the effect of SLAs on access, equity, quality and efficiency of health care provision at CHAM institutions
- 3: Examine the objectives of government, development partners and CHAM, and how these explain the operation of SLA contracts

#### **Specific objectives under general objective 1**

- Describe contract design and terms
- Understand CHAM and explore its responses to SLA payments
- Examine the impact of SLA on other health care services that CHAM institutions provide
- Assess the effect of SLA on access, equity, quality and efficiency of health care provision at CHAM institutions

#### **Specific objectives under general objective 2**

- Determine the differences in access, utilisation, quality and efficiency under varying SLA contract settings
- Assess the levels and patterns of access, utilisation, quality and efficiency
- Assess the views of key informants on access, utilisation, quality and efficiency under SLA.
- Examine factors that might have impacted on the implementation and performance of SLA.

#### **Specific objectives under general objective 3**

- Examine the stated and revealed objectives of government, development partners and CHAM in regard to SLA.
- Assess the stated and revealed objectives of individual actors representing CHAM, government and DPs.
- Explore and highlight the incentive structures facing government agencies, DPs and CHAM facilities, and how these impact on SLA.

## **4.5 Research Design and methodology**

The research design and methods presented in this section were developed with a view to achieve the study objectives. In order to understand the mechanisms and challenges posed by contracting out health care services to private healthcare providers, the study used both quantitative and qualitative methods. The qualitative component involved the use of focus group discussions and



individual interviews which were exploratory in nature to allow the researcher to understand the research problems before launching a large scale data collection effort

#### **4.5.1 Qualitative methodology**

Qualitative methodology is valued in research designs as it enables researchers to study the complex social settings of their subjects. In recent years, qualitative methods have been widely employed in health economics, where their value has been recognised. Coast (1999) has stated that researchers from a health economics perspective can draw on innovative cross disciplinary ways of working and consider researching questions that have generally been considered from a quantitative perspective. Qualitative research encompasses people's lives, personal encounters, behaviours, organizational functioning as well as interactional relationships. The contracting out relationship falls into this latter group of potential research subjects. A considerable number of studies in contracting out of health care provision in both high and low income countries have used qualitative methods (Broomberg, 1994; Allen, 2000; Palmer, 2001).

Similarly, Coast(1999) has commented that the multidisciplinary nature of health care services dictates that research in health economics utilize various research methodologies, including qualitative methodology as it incorporates a range of research philosophy and a variety of empirical methods for improving understanding and explanation.

#### **4.5.2 Quantitative methodology**

The quantitative part of the study used a cross-sectional survey of CHAM facility health workers and clients utilising health care services that SLAs cover at selected CHAM facilities across the country. Cross-sectional studies are the most commonly used in social sciences (Kumar, 2005) and are suitable for measuring the prevalence of a phenomenon by taking a cross section of the population to obtain an overall picture as it stands at the time of the study. In addition to this, cross-sectional survey designs have been used recently by Nishtar (2004) and De Costa and Diwan (2007) when they were studying the role of the private sector in Pakistan and India respectively, and these studies are similar to the current study.

#### 4.5.3 Case study perspective

The study employed a mixed methods approach within a case study design to illuminate the factors influencing the behavioural responses of CHAM institutions to the SLA and their relationships with the government. The case studies of SLAs at five CHAM health care facilities were used to provide insights and ideas on phenomena that do not occur frequently enough for researchers to obtain a large enough number of participants engaged in the phenomenon for study, e.g. specific types of contracts between government purchasers and CHAM health care facilities. In addition to this, the case studies also helped to investigate phenomena within context, where the contextual variables are so numerous and qualitatively different that no single survey or data collection approach can be appropriately used to collect information about these variables (Fellows and Liu, 2008).

The case studies therefore supplemented empirical data from the health worker and client surveys as well as focus group discussions and in depth interviews with various health care managers. The case studies also served as illustrations of real world scenarios that may be valuable by providing concrete, easy to remember examples of abstract concepts and processes. The combinations of qualitative and quantitative research designs in all study sites as well as case studies in specific facilities ensured that most of the data required for answering the research questions were captured. McPake et al. (1999) have argued that all types of health service research methods are inadequate in isolation where the questions under consideration are complex phenomena. Similarly, Mechanic (1989) has shown that the use of a triangulation approach: the collation of evidence from different sources can potentially provide more detailed information. This suggested use of a range of methods in order to collect data that could be combined to form a multi-faceted picture of issues such as those captured in this study.

However, there are limitations to the case study approach. First, Ragin (1987), Gomm et al. (2000) and Hillebrand (2001) have argued that generalisability is limited. However, Seale (1983) argues that this criticism relies on the traditional assumption that the only valid basis for making inference is that which has been developed in relation to statistical analysis and has pointed out that case studies should be used for explanation rather than generalisation. Stake (2000) has categorised case studies into three groups: intrinsic, instrumental and collective. In intrinsic case studies researchers are interested in understanding a specific case rather than making a broader

generalization from the case study. Instrumental case studies aim to, provide insight into an issue, redraw generalizations, or build theory. A collective case study is a product of several instrumental case studies and according to Stake (2000); collective case studies can be used to generalize and construct theory. Similarly, Yin (1994) and Seale (1999) observe that the basis of theoretical generalization rests in logic rather than generalisability, and have pointed out that this must be considered in the social context rather than in the case study.

Second, case studies usually take place after the fact, and consequently depend on informants' recollections of events (Sommer and Sommer, 1980). Yin (1994) has argued that this limitation can be minimised by using a triangulation approach involving cross referencing to archival and documentary records to obtain convergence from various independently obtained records. Beverland and Lindgreen (2008) have suggested that triangulation is fundamental to ensuring quality in case studies and that greater use should be made of this approach. The triangulation approach can uncover a diversity of information in a context that would allow transferability both within and across case studies. In addition to this, Yin (1994) has stated that in general, case studies are a favoured strategy in circumstances where 'why' or 'how' questions are being posed, when the researcher has little control over the events and when focus is on a contemporary phenomenon with some real life context (Yin, 1994 and others).

*“Case studies provide the details of the process that lead to results, rather than focusing on the results themselves, “getting under the skin”, of the organisation to explore the complex issues that are beyond the scope of quantitative approaches”*

(Stavros and Westberg, 2009)

However, Palmer (2001) has cautioned that even though case studies have been used extensively in health sector related research, researchers ought to keep the limitations of case studies in mind and aim at minimizing their influence. Some further limitations identified include: researcher's biases, loose application of the term case study, the bounded nature of case studies which favours containment as well as control and causality rather than the complexity and dynamism of the real world (Yin, 1994). Despite these limitations, case studies can provide stories to clarify particular social contexts. Similarly, Lincoln and Guba (1985) have stated that case studies are useful in

validating and building upon the tacit knowledge that the researcher brings to the inquiry, allowing for purposive sampling, incorporating the notion that the focus of the design can be adjusted as the process unfolds and issues of particular interest are identified.

In studies where researchers have used more than one case study, the aim is not to attain representativeness, but rather enhance understanding of the phenomenon under study. The aim for having more than one case has been termed “replication logic” rather than “sampling logic” (Yin, 1994). Replication logic seeks to find similar results between case studies (literal replication) or different results for predictable reasons (theoretical replication). Theoretical replication occurs when dissimilar results are observed for predictable reasons, by relating the case study to a theoretical framework, which analyses it differently and therefore would predict results from the different cases chosen. Replication of results across different case study sites helps to ensure that findings are not due to characteristics of a particular case study site, therefore increases the external validity (Keen and Packwood, 1999). It can therefore be argued that case studies aim to achieve analytical generalisability rather than statistical generalisability (Walsh, et al, 1997).

Hence, a number of investigators into the contracting out of health care services have used case studies (Broomberg, 1994; Allen, 2000; Palmer, 2001; Liu et al, 2007). These investigators have collected data through focus group discussions, in-depth interviews and record reviews as well as policy document analysis. In addition, investigators have used direct observation techniques to get data for research. Direct observation helps investigators to study the settings of meetings between the contracting parties and get data which could not be collected using other methods. Almost all the investigators supplemented their methods with repeat visits to study sites, where subsequent meetings were held in order to follow up on leads as they developed during the course of data collection. Similar to the studies cited above, this study used a case study approach with various data collection methodologies explained above embedded. Five case studies sites on the contracting out of maternal and child health services were chosen not for the purpose of increasing the representativeness of the sample, but for theoretical replication.

#### **4.6 Ethical issues**

Ensuring informed consent, confidentiality and anonymity of key informants (as well as the institutions they represent) were the key ethical principles that were adhered to. Ethical approval was sought and granted for the study at four levels. 1) Queen Margaret University (QMU) ethics committee in Scotland, 2) College of Medicine research ethics committee (COMREC) in Malawi, 3) CHAM secretariat upon approval from COMREC and 4) letters were written to all participating CHAM facilities requesting their involvement in the study in addition to the notification letters provided by COMREC and CHAM.

Key to the ethical requirements of this study was the promise to maintain the anonymity of respondents and the facilities involved in the publication arising from this research. Consequently, the names of the participating key informants are categorised into broader groups to mask their identity. The groups are CHAM representative, health worker, DHMT, DHO and MoH official. The case study sites are presented with alphabetical labels from A to E.

#### **4.7 Data collection tools and study respondents**

This subsection describes the data collection tools and study respondents. The participants for this study were drawn from both the public health sector (District health management team-DHMT) and CHAM institution managers and key personnel. The data was collected from 9 facilities in 8 districts around the country as illustrated in table 4.1, on page 91. The districts, facilities and respondents, were sampled purposively to represent a range of sizes, facilities expected to be available and geographical area of the country. The data was collected from August 2010 to July 2011. The participants (facilities, districts and respondents) in the sample were approached and informed of the study, and their consent requested to participate.

Data collection tools and methods were adapted from Nigenda and Gonzalez, (2009), McPake et al. (1999) and Asenso-Okyere et al. (1997) whereby open ended and closed ended questionnaires were employed to get information on service level agreements and a survey questionnaire was administered at selected CHAM institutions in the sample, followed by In-depth interviews focus group discussions and detailed case studies of 5 CHAM facilities that had signed SLA contracts.

Open ended and closed questionnaires in the survey provided information on the number and type of CHAM institutions e.g. hospitals, clinics, health centers, diagnostic centers and pharmacies to indicate their capacity to provide health care services, the number and type of CHAM facilities located and operating in the urban areas like city centers, municipals and towns and rural areas. This is an important variable, as where a CHAM facility is located, has consequences for access, equity and quality due to factors like distance and availability of skilled health personnel, equipment and medical supplies. The survey also provided information on the kind of health services that CHAM facilities provide under SLAs and information on how health workers and clients (patients) perceive SLAs.

In-depth interviews and focus group discussions provided information on the perspective of health care managers and policy makers on the performance (access, quality and efficiency), challenges in implementing the policy (negotiation of contracts, non-renewal of contracts, non/delayed payment, prioritization issues at the district health office, perverse behaviors by both CHAM and government representatives) and how SLAs can be improved (monitoring and evaluation, training and commitment by all involved ). Case sites provided information on specific service offered, utilization patterns, amount of financial resources the government is remitting to CHAM facilities and issues specific to facilities.

#### **4.7.1 Piloting and pre-testing of research instruments**

The study instruments were pretested at Mlambe Mission hospital, a facility not included in the study from Blantyre district. The pre-testing focused on checking the clarity of the questions, to ensure that they were not ambiguous or misleading. Additionally, the pretesting helped to determine the amount of time required to administer the tools. The instruments were then revised in response to the pre-testing results.

#### **4.7.2 Research team and training**

A team of four research assistants and a supervisor was deployed to collect data from the sampled health care facilities. The team comprised two members with nursing or clinical background, one familiar with quantitative inquiry and one familiar with qualitative interviewing. The research team was provided with a one day training course to familiarize them with the SLA strategy and ensure understanding of the research methods to be implemented during the research. Training

was on strategy undertaken to minimise interviewer bias. The areas covered included research procedures, interviewing and probing techniques, completing questionnaires and management of completed questionnaires and qualitative data.

## **4.8 Research tools**

Research tools are all instruments, materials, activities or methods necessary to undertake research. This section briefly explains the tools that have been used in this study and the kind of data each extracted.

### **4.8.1 Health Management information system (HMIS) review**

HMIS data were collected from health care facilities sampled as case study sites. These assessed the different interventions covered by SLA at the facility. The tool focused on number of people who had accessed healthcare services before and after SLA were introduced. The HMIS analysis looked at patterns of utilization before and after the introduction of SLAs and the link of utilisation data with financial flows between CHAM facilities and the DHO.

### **4.8.2 Review of policy documents and annual reports**

A review of annual reports and policy documents was carried out with the aims of understanding the policy environment on contracting out and SLA policies as well as complementing and validating what was reported in HMIS. Furthermore, at each district health office and CHAM facility, minutes of meetings between the DHMT and facility managers as well as copies of contracts were collected and studied. After the minutes and contracts were studied, issues needing clarification were followed up with either the facility manager or DHMT.

### **4.8.3 Exit interviews for maternal and child health**

This tool collected information on process of care provision with attention to cost barriers (user fees and expenses related to; transport, food, accommodation etc) and non- cost barriers, as these are thought to prevent people from accessing health care services. The tool also collected information on the general perception of clients on the service provided. Clients were recruited after they had received healthcare services on the day of the interview. Clients from antenatal clinic, postnatal and care givers of sick children were interviewed. The study aimed to interview a

maximum of 35 clients per facility. However, due to low numbers of clients at some facilities, the number of people interviewed was less than 35. A total of 258 clients who attended the health care facilities for maternal and child health care services were recruited in the client exit surveys. The majority of respondents (253) were female, representing 98% of all clients recruited in the study. This reflects the nature of the service as maternal services and child health services are meant for women, and children who in general are supported by their mothers.

#### **4.8.4 Health worker surveys**

Health workers survey were designed to supplement information collected from HMIS, annual reports and client exit interviews. In addition, the tool also focused on the implications of SLAs for the performance of health care providers. Health workers were also interviewed on their understanding of SLAs and any role they had played in the establishment of the agreements. Due to the timing of the study and limited numbers of staff in some healthcare facilities, it was not possible to interview all health workers as this could have led to disruption of service provision and in some cases closing the facility during the days of the study. In order to avoid disrupting provision of healthcare services, the research team allowed some health workers to complete the survey questionnaire on their own when they were free from serving patients. This helped the facility to remain functional while collecting the data. A total of 93 health workers completed the survey questionnaire

#### **4.8.5 Qualitative interviews with policy makers and Health Managers**

Interviews were aimed at exploring the policy regarding contracting out in general and specifically the policies and programs on SLA between CHAM facilities and district health offices. The following policy makers and health managers were interviewed: Director of Planning, MoH; Director of clinical services; deputy director of HMIS; CHAM secretariat Executive Director; CHAM facility managers (Hospital Administrator, Matron, Medical Director, and Accountant) and Ministry of health district health office management team (DHMT).

At the district health office interviews were held with the DHMT members. The DHMT members were asked to explain how their relationship with CHAM facilities had evolved over time, with specific reference to the changes that contracting out had introduced following the introduction of



SLA. Respondents were asked to identify issues of contention that had arisen between the district health office and CHAM facilities, how such cases arose and how they were resolved. They were also asked about the payments, the changes in managing them, how they had been affected by SLA and strategies that had been implemented to improve patients' access and utilisation of SLA services at CHAM facilities.

A total of 27 in-depth interviews were conducted with health managers at various levels as outlined above. To ensure consistency, all qualitative data were collected by the investigator through a voice recorder in focus group discussions and in depth interviews. The recorded voices were subsequently transcribed verbatim. The transcriptions were then reviewed to provide an understanding of the themes emerging from the information provided by informants (primary analysis). The main themes presented at this stage were external factors to contracting out, difficulties of contracting out, capacity problems in CHAM facilities as well as government agencies, conflicting objective functions, problems introduced by contracting out in general and contracting out problems specifically associated with health care provision.

Table 4.1 provides a summary of data collection, showing the districts involved, health care facilities sampled, type of tools used and the number of respondents.

**Table 4.1: Summary of Data collection**

District visited	Type tool	Number of respondents
Nsanje	Health worker survey	12
	Client survey	25
	Interview questionnaire	1
Chiradzulu	Health worker survey	11
	Client survey	31
	Interview questionnaire	2
Mulanje	Manager Interview/FGD	1
	Health worker survey	12
	Client survey	30
	HMIS	
	Interview questionnaire	2
Phalombe	Manager Interview/FGD	2
	Health worker survey	13
	Client survey	33
	HMIS	

	Interview questionnaire	1
Zomba	Health worker survey	9
	Client survey	29
	Interview questionnaire	2
Mangochi	Interview	1
	Health workers survey	7
	Client survey	26
	HIMS	
	Interview	1
Dowa	Interview	1
	Health workers survey	12
	Client survey	34
	HMIS	
	Interview	1
Mzimba	Health worker survey	5
	Client survey	18
	FDG	1
	Health workers survey	12
	Client survey	32
	HMIS	
	Interview	1
Lilongwe	interview	5
	Interview	3

Health worker survey: N = 93

Client exit interview: N = 258

Interview with health care Managers: N = 27

## 4.9 Data Management and analysis

### 4.9.1 Data Management

Data management entails the processing, preparation for analysis, documentation and storage of information resulting from the data collection exercise. It is one of the essential areas of responsible conduct when carrying out research. Good research data management practice permits reliable confirmation of results and allows new and innovative study built on existing information. In this study the first stage in data management was the capturing of the quantitative data manually into excel sheets. The data were checked for errors, then labelled and stored on the computer and disks to make it ready for analysis. Qualitative data were managed by recording all the interviews with a voice recorder. The interviews were then transcribed verbatim, the

transcripts labelled and stored in the computer and disks prepared to make them ready for analysis.

#### **4.9.2 Data analysis**

Data analysis entails how the raw data is chosen, evaluated and interpreted into meaningful and significant conclusions that other investigators and the general public can understand and use. Since the study used both qualitative and quantitative methodologies in collecting data, it also used both qualitative and quantitative data analysis techniques.

##### ***a) Quantitative data analysis***

Quantitative analysis involves presenting and interpreting numerical data using descriptive statistics such as measures of tendency (mean, median and mode) as well as measures of variation (range and standard deviation). The descriptive statistics enable a picture of the data that were used in the research project. Data were managed and analysed using EpiInfo and SPSS version 19. In-built range checks, consistency checks and controls for skip patterns were used to minimize data entry errors. Data cleaning was done by the investigator in collaboration with the research team.

##### ***b) Qualitative data analysis***

Qualitative data analysis is characterized by a range of procedures and processes in which the qualitative data that have been collected are transformed into the form of explanation, understanding or interpretation of the people and situations that are being investigated. Qualitative data analysis generally goes together with interpretative philosophy. The key idea is to examine the meaning and symbol content of the qualitative data. The qualitative data were transcribed verbatim in Word and then analysed using Nvivo 9 software and manual methods to achieve better results. The analysis drew out common and minority views. Quotations have been used in presentation of the results to illustrate the themes and issues reported by the study respondents.

The analysis of qualitative data was carried out in three stages: stage one, during data collection and transcription processes, where themes/codes were identified and arranged into a table. Further tables were developed and elaborated as the data collection and transcription process proceeded. This allowed the listing of all possible themes/codes as they were reflected in the data and probing for specific issues identified from themes as well as permitted a process of

simultaneous data collection and analysis. The second stage of data analysis involved showing common findings and disaggregated by the type of contracting arrangement (more attention was paid to the difference in services provided and type of contract, e.g. SLA contracts with CHAM facilities designated as district hospital as opposed to general SLA contracts covering Maternal and child health services only). The comparison allowed for the differences in contract difficulties that arose from peculiarities of the contractual settings. The third stage of the analysis showed findings related to the views of different informants on capacity, experiences and external factors impacting on SLA.

#### **4.10 Conclusion**

The analytical framework and an economic formalisation of the principal agent framework have been presented here, showing the various components of the contractual relationship between the principal (public sector agency) and the agent (private health care provider). The framework has also demonstrated how the various components interact with each other and affect the outcomes of the contractual relationship. The main aims and specific objectives of this study and the related propositions based on each of the key theories used have been reported in this chapter.

The combination of quantitative and qualitative methodologies in the context of case studies aimed to facilitate studying the mechanism and challenges that government faces in contracting out health care provision to private health care providers. Despite many studies and initiatives to promote contracting out of health care provision, there has been less attention paid to the analysis of transaction costs, institutional settings and objectives of the parties to the contracts. This study attempted to fill this gap by analysing the environmental factors but also relating this to the outcome variables of contracting out, namely, access, equity, quality and efficiency. The next chapter will provide an overview of the data by exploring the perspectives of informants and experiences in case study sites.

## **Chapter 5: Overview of the data**

### **5.0 Introduction**

This chapter describes the data; particularly outlining the perspectives of different informants on SLAs in as far as health care provision is concerned, and its implications for equity, quality and efficiency in the delivery of health care services through CHAM facilities. The first section of the chapter summarizes the perspectives of government representatives at Ministry of Health Headquarters, CHAM secretariat officials, District Health Management teams, CHAM facility management teams, health workers and clients. The section also provides information from policy documents and HMIS data.

The second section of the chapter describes five case studies that were carried out as part of this study. Due to ethical reasons and to protect the confidentiality of the case study sites, the study sites in this thesis will be referred as sites A, B, C, D and E. This is followed by a summary of themes emanating from this study and these themes are explored further in the subsequent chapters.

Most respondents stated that SLA between CHAM facilities and the government through the DHO is a good mechanism which is enabling access for people who would otherwise not achieve it. However, they have different perspectives on how the SLAs are working as outlined here, as well as in the case studies.

### **5.1 MoH representatives' perspective**

The perspective of MoH representatives were varied in that, while some MoH informants claimed that SLAs are a good arrangement between government and CHAM facilities, other MoH informants claimed that SLAs are a waste of public resources. The informants who claimed that SLA was a good arrangement, argued that, despite the challenges that government agencies and CHAM facilities were facing in their contractual arrangement, access to maternal and child health services had improved in some remote areas of the country due to SLA.

On the contrary, MoH informants who purported that SLA was a waste of public resources, and

were concerned with the increase in the number of SLA contracts in the country, and considered reducing the number of SLAs. They alleged that there was duplication in some areas where SLAs have been signed when a functional public healthcare facility was present. These informants further claimed that some SLA contracts were initiated by CHAM facilities as a way of generating income.

Similarly, some MoH informants claimed that there was a conflict of interest on the part of CHAM, and argued that, CHAM secretariat and facilities played a leading role in constructing the current price list (2006), a greater role than that of government. This they claimed was an indication that CHAM facilities are only interested in the financial resources from SLA and not the provision of quality services to the poor population as claimed in various CHAM documents.

Despite having a clause in the SLA contract on monitoring and evaluation by MoH, little is done. Respondents were asked to comment on why little and in most cases no monitoring exercises were conducted. The respondents commented that there was no budget line for monitoring and evaluating SLA activities. The respondents claimed that the absence of a budget line for monitoring and evaluating SLA was due to the trust that government had in CHAM facilities, and expectation that they would perform in line with their religious beliefs. The disparate perspectives of MoH informants and seemingly absence of monitoring and evaluation of SLA as briefly outlined in this section will be explored further in chapter 6 and 7.

## **5.2 CHAM secretariat representatives' perspective**

Officials from the secretariat pointed out that, SLAs had helped to extend coverage of maternal and child health care services through CHAM facilities. However, they were concerned with the government's intentions to reduce the number of SLAs. They alleged that government was planning to reduce the number of SLAs by half. They expressed the fear that if the decision was implemented it would leave a lot of underprivileged people with no access to proper medical care.

On a different note, CHAM officials alleged that government was exposing CHAM facilities to financial risks due to delayed payments for SLA services provided, as this delay forced CHAM

facilities to borrow from financial institutions and pay interest. The officials further alleged that government reluctance to revise prices for drugs and medical supplies had strained CHAM facilities' financial resources, exposing them further to financial risks.

Furthermore, CHAM officials alleged that, some CHAM facilities have wanted to stop providing SLA services, but feared this would impact on their relationship with the government. The officials argued that the facilities were concerned that if they chose to stop offering services under SLA, the government might withdraw the support it provides for salaries, drugs, transport and other agreements such as the support government provides to CHAM training institutions.

### 5.3 DHMT perspective

Despite agreeing that CHAM facilities through SLA are helping needy people to utilize essential health care services, the general perception among the members of DHMTs was that CHAM facilities were expensive and overcharging the government for simple procedures which would cost less in public health care facilities. One DHO concluded that most DHOs had lost interest in SLAs and felt they were being over charged by CHAM facilities:

*“Every item used is charged, we have over prescription problems with CHAM, bed space charged at K60.00, charging administration fees, they argue that it is for utilities bill”.*  
(DHMT respondents) – D: 1

The DHMT also reported practices that they claimed some CHAM facilities have been involved in, making them suspect that this could be practiced by many CHAM facilities that have signed SLA contracts. One DHO argued that some CHAM facilities are taking SLA as a way of generating income over and above costs incurred; he gave an example of a facility transporting three patients in one ambulance but presenting three separate invoices for three ambulance trips instead of one. They also claimed evidence of “Ghost” patients who some CHAM facilities have claimed received health care services from their facility, while monitoring and evaluation exercises failed to establish the existence of these clients.

DHMT members also raised concerns that finances meant for SLA interventions are diverted to other activities at CHAM facilities including infrastructure projects. *“Look what SLA money has*

*done for us*”- A DHMT informant claimed to have been shown an administration block built by finances that the facility received for SLA services. The informant claimed to be able to demonstrate that, even though SLA financial resources are not meant for infrastructure, there are instances in which they are used that way.

Members of the DHMT were asked to explain whether SLA payments were included in the preparation of the DIP. Most DHMT members responded that there is always an allocation for SLA payments in the DIP. Following from the response that SLA payments are included in the DIP, the DHMT was then asked if it always makes payment to CHAM facilities as outlined in the DIP. The response to this was that there are times when what the district receives from treasury is less than the budget, and the DHMT prioritizes other expenditure. They also added that even when they have received the whole allocation for that month, they would still prioritise other budget items such as fuel and allowances, and pay debts incurred during previous periods before SLA payments would be considered. The DHMT further claimed that SLA payments are not made due to facilities exceeding their allowable limit “*ceiling level*” and utilization figures not matching government expected figures. When the respondents were asked how the amount of financial resources allocated to SLA in the DIP was derived, most of them were not sure how this was derived.

This kind of response was provided by members of the DHMT in all 8 districts involved in the study, raising concerns that those responsible for allocating resources for SLAs activities have not been part of the financial decision making concerning SLAs. This may partly explain why some DHO feel they are paying too much towards SLAs.

Resentment towards CHAM facilities was expressed, along with a lack of understanding as to why the government involves CHAM facilities. Some DHOs argued that the public sector should not be involved in any transaction with CHAM facilities and that the government should concentrate on its own facilities.

*“The government should just build their own hospitals and let CHAM continue with their business”* (DHMT informant). – D: 2

These sentiments suggest that, some DHMTs perceive that public resources should only be utilised within the public system.



## 5.4 CHAM facility management perspective

CHAM facility managers were asked to present their perspectives on the impact of SLA in their catchment area. Most managers claimed that SLA had improved the hospital's relationship with government and politicians who encouraged their electorate to access free health care services through CHAM facilities. They further claimed that SLA was a significant step that the government had taken in order to address the problem of high maternal and infant mortality in the country. The managers pointed out that the policy had led to increased number of institutional deliveries as well as deliveries conducted by skilled birth attendants. The managers speculated that if SLA would be scaled up to include all EHP conditions, it could cater for further health needs. However, the managers expressed the view that the operations of SLAs were thwarted by a number of factors originating from the government side. One manager commented that, *"Instead of going forward we have gone back"*. Some of the factors that have caused CHAM facility managers to conclude that little progress has been made with SLAs are briefly explained below.

### 5.4.1 Staff turnover

Concerns were expressed by CHAM managers that high staff turnover at the district health office was impinging on the progress of SLA. They contended that changing the DHO frequently affected the way SLAs operate: *"I did not sign that so that should not concern me"*. In some instances it was claimed that not only the DHO post was frequently rotated, but CHAM facility managers as well.

### 5.4.2 Capacity problems

Some managers argued that other DHOs do not understand the relevance of the SLA and suggested that there is need for new DHOs, particularly the ones who are not very familiar with the private health sector to understand SLAs and how to negotiate contracts on behalf of the government:

*"our experience in costing SLA has been like one blind person leading the other, we did not include items like gloves, cotton wool delivery packs, etc. in the initial costing with the DHO, our experience is that these items are needed each time there is a delivery therefore very costly,"* (CHAM informant). – CH: 1

Some DHOs were reported to have inadequate knowledge of the agreement or opportunity to understand the mechanism before committing themselves to it. Related to this, one respondent argued that,

*“..... some are not mature enough to handle the DHO office and understand the implications of their actions”.* (CHAM respondent) – CH: 2

#### **5.4.3 Delayed or non-payment**

The views of DHMT members on delayed or non-payment have been discussed above. CHAM respondents argued that the problem strained CHAM institutional budgets with the implication that other services that CHAM facilities have been providing to the community are not effectively provided or not provided at all as resources are tied up by SLA:

*“We are denying people other services that we could offer them using the money that we have spent on SLA”.* (CHAM informant) – CH: 3

Most CHAM managers suspect the delay and non-payment of SLA bills by the district health office may be traced back to the three factors described earlier.

- 1- Staff turn-over at the DHO office
- 2- Lack of understanding of the SLA and its foundation
- 3- People advancing their own interests and not those of government

#### **5.4.4 Cost not directly related to health care provision**

Most managers expressed concerns about time spent on meetings with DHMTs to negotiate payments and discuss SLA related issues. One manager pointed out that,

*“The hospital management has been to the district and zone office several times to discuss the payment issue,”* (CHAM manager). – CH: 4

In addition, managers alleged that SLA contracts do not cover overhead costs e.g. water, electricity and phones; they claimed that the large number of clients coming to CHAM facilities due to SLA had significantly increased overhead costs.

#### **5.4.5 Price renegotiation**

CHAM facility managers indicated they have been proposing a price revision to reflect the current market prices for inputs required to provide SLA health services. The disagreements about prices for drugs and medical supplies were argued to have strained the relationship between government and CHAM facilities. Some CHAM facilities indicated they had scaled down and discontinued provision of SLA health services as a result.

For instance, a CHAM respondent claimed that as part of antenatal consultations, women are provided with SP, folic acid and iron tablets. The price of these three drugs was claimed to be over K1000. In addition, every woman who attends the antenatal clinic is supposed to be screened for base line haemoglobin VDRL - syphilis. The test kit for this kind of screening was stated to cost K400. However, it was claimed that CHAM facilities are only reimbursed K200 for the four consultations that women undergo and the drugs that they provide. Following from this the informant stated that:

*“Instead of the government subsidizing CHAM, CHAM is subsidizing the government”*

(CHAM informant) – CH: 5

Most CHAM facilities claimed to have invited government to discuss the issue, but indicated that government had not adequately responded:

*“CHAM has called for a meeting with government to negotiate prices and other conditions on SLA but government does not take CHAM serious on SLA”*

(CHAM informant) – CH: 6

#### **5.4.6 Political involvement**

The involvement of politicians in SLA has created challenges to both CHAM facilities and DHOs. One administrator commented that SLAs are politically sensitive and difficult to stop:

*“There are times we wish we had come out of SLA arrangements but it is difficult to do so due to the politics surrounding the arrangement”* (CHAM respondent) – CH:7

The informants claimed that some SLA were not instituted based on the identified need for the services by the DHO and other major stakeholders, but on political rationales with the implication that some CHAM facilities have signed SLA without proper assessment of their capabilities to provide the contracted services. The informants further claimed that these politically motivated SLAs are often based on directives from senior government officials or politicians, as such; these SLAs are not planned for and not included in the DIP, making it difficult for DHOs when it comes to making SLA payments.

#### **5.4.7 Increase in patient load**

Some managers expressed concern that the removal of user fees through SLA has brought an increase in the number of patients coming to CHAM facilities for treatment beyond what was estimated. The increase in the number of patients was argued to have implications for the facilities by exerting pressure on resources such as health workers, infrastructure, equipment, drugs and medical supplies. An informant alleged that,

*“Due to high numbers of children’s admissions there was congestions in the children’s ward, there was nothing we could do but transfer some children into the male ward”*  
(CHAM informant) – CH: 8

Similarly, an informant claimed that the facilities budget for drugs and medical supplies increased without there being sufficient storage for these supplies. The informant stated that,  
*“We moved from buying 200 bottles of medicines per week to 800”* (CHAM informant) – CH: 9

#### **5.4.8 Sustainability of SLA**

The sustainability of SLA was questioned on the basis that there were no earmarked funds. One informant expressed the view that government rushed to implement SLA before a thorough study

of population needs was done and also that government has failed to facilitate the functioning of SLA. An informant claimed that SLAs were ‘donor driven’, introduced under SWAp as a mechanism to increase coverage of health care services particularly focusing on maternal and child health services.

The sustainability of SLAs was also considered in relation to potential future changes in governments through the electoral process. An informant pointed out that the incumbent government may favour the provision of health care through CHAM, while the new government may prefer to strengthen the public sector. This is summed up by one manager, who pointed out that:

*“CHAM should understand what government is trying to change not just in the interim but also in the future because those leading the government now can change, will the future government continue with SLA?”* (CHAM respondent) – CH: 10

## **5.5 Health workers perspective**

CHAM health workers who were not part of the management team were asked to complete a survey on their perceptions of the SLAs, specifically on utilisation of healthcare services, staffing levels, workload, working hours, training on SLA, working conditions, feedback received from patients and responsibilities entrusted. Qualitative information was collected in subsequent discussions with health workers in case study sites. The main themes that emerged from the survey will be discussed first. What was observed is that generally health workers perceived SLA as a good mechanism with the potential to improve access to health care beyond current levels. However, most respondents felt that workload was excessive and required more health workers to handle the number of people coming to CHAM facilities to utilize health care services under SLAs. The informants claimed that workload problems were acute in some facilities to the extent that some maternity deliveries were attended by health workers who are not midwives.

*“Sometimes unskilled health workers are the ones who deliver mothers at the hospital.... we know they are not trained health workers but what can one nurse do? She is a human being and gets tired”.* (CHAM health worker) – CHH: 1

Health workers expressed concern about payment delay as this affected their work in the sense that the facilities are not able to acquire drugs and other medical supplies essential to some medical procedures. One health worker commented that, *“Mothers have to bring a new razor blade, plastic sheet and a plastic basin for infection prevention,”* to avoid cutting corners during labour

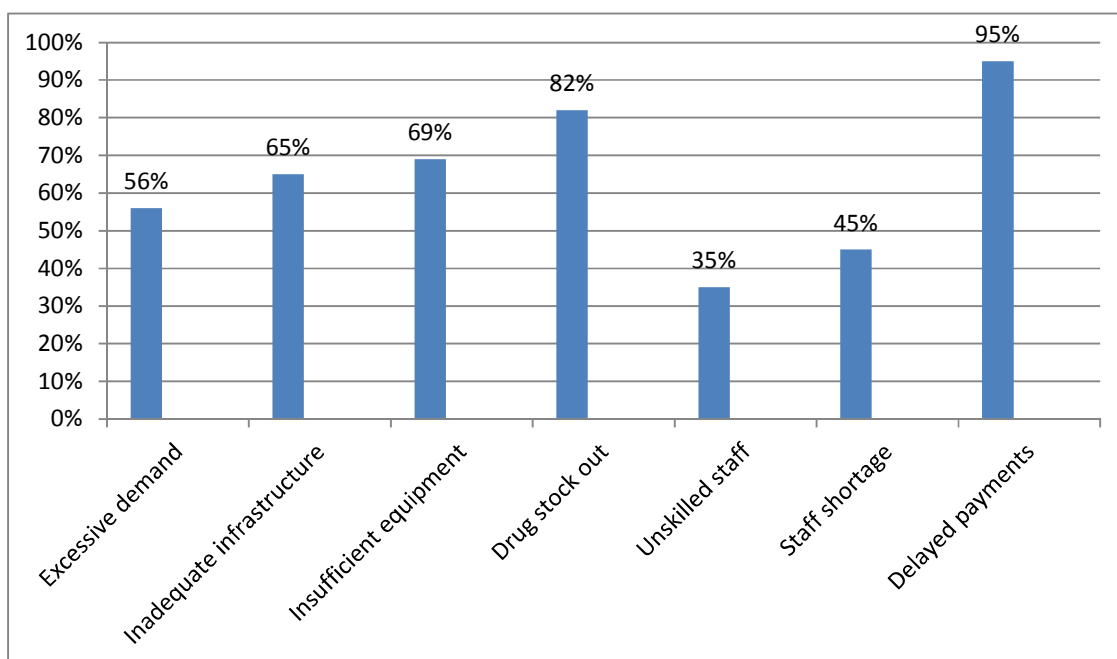
Some health workers claimed that, since the introduction of SLA there are people who are overusing the services, particularly child health care. They alleged that such people bring their children to the hospital even when they do not necessarily require any medical care. Similarly, some informants alleged that in some facilities people who can afford to pay for their health care services were benefiting from SLA services. Health workers also reported that some of the people who came to access SLA services were not from the facility’s catchment area, or even from Malawi particularly at facilities that are in the border districts. Some commented that there is need for the introduction of a national identity card to ensure that the system is not abused.

Furthermore, some health workers claimed that the overuse of services by people within CHAM facility catchment areas and treatment of those who are not from the catchment area may partly explain the disparity between the estimated SLA services utilisation figures by the Ministry of Health and what actually occurred. The difference between these figures is thought to be one of the reasons why the government mistrusts facilities as they suspect them of inflating figures to enhance their revenue.

A minority of health workers expressed ignorance about the operation of SLAs as they were not consulted during the negotiation. They indicated that they came to know about SLAs when payments started becoming a problem, and created problems such as shortage of drugs and medical supplies as well as money to pay locum staff allowances, at which point management started briefing them on the delays. Similarly, they indicated a lack of understanding as to what health conditions SLAs cover. Figure 5.1 provides a summary of some of the main impacts of SLAs from health workers perspective. The figure illustrates that 95% of health workers perceive

that delayed payments had an impact on service provision while only 35% perceive that the shortage of skilled health worker is a problem.

**Figure 5.1 Main problems faced by CHAM facilities: health workers perspective (N=93)**



## 5.6 Clients perspectives'

Client perceptions were evaluated through a client survey that was administered at all facilities involved in the study. Specific questions relating to SLAs, content of the services provided quality of health care, provision of appropriate diagnosis and treatment, drug availability, referral mechanisms, provision of food and bedding, transport, user fees, state of the health facility and staff attitude. The sub-sections below highlight findings from the client survey.

In general, clients were happy with the introduction of SLA, as they were no longer required to pay user fees which in the past acted as a barrier and prevented or delayed them in seeking medical care. However, there was confusion by some clients on what health conditions are covered by SLA. For instance, at one facility children who are treated as outpatients are required

to pay user fees, while those treated as inpatients are covered by SLA. Similarly, for pregnant women, there are other conditions that the pregnant woman may suffer from but are not covered by SLA. It is suspected that these kinds of confusions may have impact on access to maternal and child health services under SLAs.

Patients in some facilities alleged that it took a long time to be served; some claimed that they spent the whole day waiting only to be told to come back the following day.

*“There were many people at the hospital when I came the other day, there was a long queue, I went back home and have come back today”* (Patient informant) -CP:1

Similarly, some clients claimed that in their previous visit to the facility they were advised to go back home without drugs but asked to come back to collect the drugs when they were available while others claim that they were given prescriptions to buy from the pharmacy .

*“They asked me to come back after two days to collect the medicine”* (Patient informant) -CP: 2

In addition, some women claimed that when their time to deliver was due they had to wait for some time before going into the labour ward. The informant stated that,

*“The time had come for the baby to come out but the nurse was busy with my friends who were also delivering, my mum stayed with me”* (Patient informant) -CP: 3

The reason for the delay in attending to the patient as expressed here is due to imbalance in patient health worker ratios as well as facility capacity problems, for instance, there are CHAM facilities where the labour ward only handles one case at a time, due to space and staffing problems.

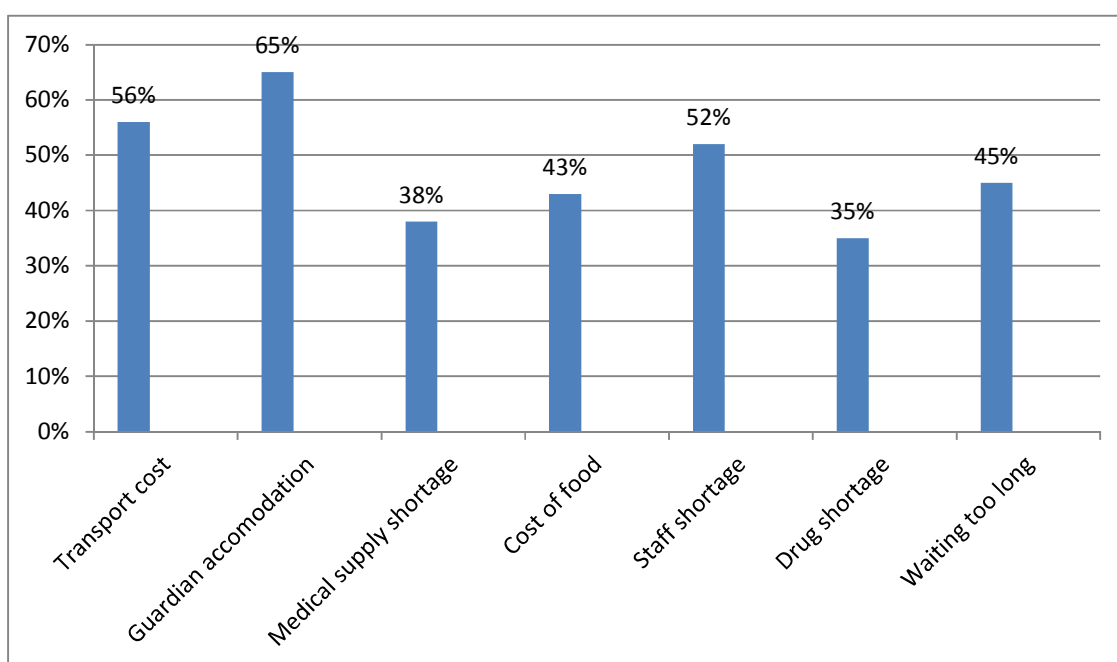
Furthermore, despite the removal of user fees through SLA, women still find it difficult to use the facility because of the cost of food and transport. CHAM hospitals do not provide meals for their patients. The amount of money required for meals can represent a burden:



*“I have been here for 2 weeks waiting for delivery; they have treated me well, but have spent a lot of money on food for me and my guardian.”(Patient informant) -CP: 4*

Figure 5.2 summarises some of the main challenges of SLA from the client’s perspective. The figure illustrates that 65% of the clients felt that guardian accommodation is a challenge despite not paying for services, while only 35% perceived that drug shortage was a problem.

**Figure 5.2: Main problems from client’s perspective (N =258)**



## 5.7 Document review and HMIS

This section describes the documents that were reviewed and HMIS data sources that were analysed during the study. The section also highlights some of the challenges encountered in accessing documents and HMIS data sources used in the study.

### 5.7.1 Document review

Relevant policy documents, reports by major stakeholders in the health sector and published research findings addressing SLA issues were reviewed. The document review strategy involved: consulting of relevant policy document and reports; following up relevant materials in reference

lists in policy documents, reports and published journal articles reviewed; consulting some internet resources ( DFID, World Bank and World Health Organisation).

Despite the government being in the forefront of promoting SLAs, relevant policy documents related to SLAs were hard to locate at Ministry of Health headquarters. Most of the reviewed policy documents were provided by CHAM secretariat, CHAM facilities, bilateral organisations involved in SWAp and international as well as local NGOs. For instance, a copy of the SLA template that is used in all SLA contracts was provided by CHAM secretariat, after efforts to source it from the Ministry of Health headquarters yielded nothing.

The SLA template is one of the important documents prepared to guide the implementation of SLAs. The template stipulates that:

*“The total monthly fee of the agreement shall follow principles of performance based financing and the invoice shall therefore be a multiple of the agreed intervention fees times the monthly case volume with a maximum foreseen budget of MK (ceiling). Establish baseline data at the onset of the SLA for key indicators to be used to measure performance, on the basis of population numbers and HMIS targets for a particular intervention”*(SLA template).

Similar to the SLA template, is a framework for SLA (Eldridge and Meis, 2007), which among other things provides information on the selection criteria for SLA facilities, process for implementing SLA, monitoring and evaluation details, quality of service measures, standardized costing, renewal procedures and responsibility and task allocations. The framework stipulates that monitoring of the SLAs needs to be done on an ongoing basis and states that:

*“Monthly activity reports need to be sent to the DHO together with the monthly invoice DHOs need to compile monthly reports, disaggregated by facility, into quarterly reports for ZSHO and proprietor. The format for activity report is not strictly prescribed, but should include a breakdown of the contracted interventions, relevant HMIS data,*

*proportion of patient revenues covered by SLA revenues, achievements, challenges and strategies to address the challenges in the month”(Framework for SLA. 2007).*

In contrast with what has been documented in the two policies above, CHAM report (2009) has stated that,

*“Not all CHAM facilities adhere to this reporting system. Most of the facilities do not submit their reports timely and 21% does not even submit at all. 81% of those who submitted their reports in the 2<sup>nd</sup> and 3<sup>rd</sup> quarters submitted to the DHO’s but not to CHAM secretariat..... This mode of reporting results into incomplete data for CHAM secretariat which may not be a true representative of all the CHAM facilities” (CHAM report, 2009)*

The report further stated that,

*“Some of the HMIS reports that are submitted are not completed fully for example out of the 32 reports received by CHAM secretariat in the fourth quarter 13 were incomplete representing 41% of the reports. Health facilities tend to leave out filling indicators which they are not very conversant with and at times also those which they think they are constant and they have already reported on them, for example human resource and infrastructure status. This makes such indicators incomplete and not able to relay some important information”. (CHAM report, 2009)*

Most of the reviewed documents indicated that there is an established protocol to follow when establishing SLAs. However, for various reasons this protocol has not been followed by both CHAM and government representatives. GTZ (2009) has shown that, in some cases the signing of an SLA had been driven by pressure from MoH headquarters, proactive CHAM proprietors/Managers and politicians without allowing ample time for the DHMT to think or follow through the prescribed process. CHAM (2009) and GTZ (2009) have pointed out that, one of the consequences of not following the recommended criteria for participating in SLA was that some CHAM facilities had signed SLA without proper assessment of their capacity (financial, human resources and infrastructure) and without future planning for implications of increased patient numbers on finances, human resources and infrastructure. This suggests that in some instances DHOs were side-lined by politicians and their counterparts in the MoH. The

implication of this state of affairs can be seen in the level of commitment by some DHOs to SLA and the impression and perception they have that CHAM facilities are more interested in the financial resources from SLA and less in the provision of health care services (GTZ, 2009).

Major stakeholders in the health sector identify the need to scale up SLA to more health care facilities so as to reach the expected national target. However, they are concerned that the existing resources (financial, human resources and infrastructure) and some of the procedures used in the negotiation process are major constraints to successful implementation of SLA. Their conclusion is that, if SLA is to improve and help strengthen the provision of health care services, there is a need for MoH to examine and improve the management, coordination and collaboration with private health sector health care providers.

*“MoH did not define what exactly SLA is all about- are they outsourcing to CHAM or is it supporting CHAM, or is it a mixture of both? Clarity of this could assist in improving a lot of things on the ground” (GIZ, 2011)*

While the DHO is intended to be a lead health decision maker at the district, the SLA framework seems to give more responsibility to Zone officers, who are not intended to be decision makers and implementers at the district. One DHO has commented that,

*“My view is that the ministry of health has not provided clear guidance and direction on SLAs to the district.... there is nothing documented to guide the district” (GIZ, 2011)*

These views may shed some light on the prolonged and seemingly uncoordinated ways of handling SLA activities and also question the relevance of the SLA template and framework that was discussed earlier. In addition, these views may point to the fact that those responsible for managing SLAs have not yet acquainted themselves with the contents of these documents. This observation has also been documented by GIZ (2011) in a document that stated:

*“Most CHAM facilities and DHOs are not aware of the existence of this document mainly because of poor circulation and also high staff turnover within the facilities affecting institutional memory” (GIZ report, 2011)*

### 5.7.2 HMIS

HMIS has three dimensions, information technology, facilities and personnel. Thus, HMIS requires use of computers and other information technology equipment as well as people who are capable of using the computers and related technology. Apart from the initial equipment costs required, in most of the facilities there was no long term planning for information technology facilities required to have an operational HMIS. In other facilities the HMIS planning was only allocated the initial costs and was never completed.

In addition, it is difficult to attract and retain skilled personnel in rural areas due to difficult conditions in such places; some hospitals have resorted to recruiting unskilled personnel as long as there is somebody seen doing the work. For instance, in two of the 9 surveyed facilities, a gardener and a cleaner with no training in basic data collection and analysis as well as basic computer training were recruited to oversee the HMIS function. Generally, lack of computers and computer literacy is often a challenge in rural areas where CHAM facilities are mostly located. Some people in such settings have never used computers, the computer is often considered something for the privileged or people with high status in the society. In such environments, people resort to doing everything manually and miss opportunities to link data through computer technology.

HMIS data were collected from facility patient's registers and records of women and children who attended maternal and child health related services at the facilities (i.e. antenatal clinic attendance, maternity delivery, emergency interventions, and maternity complications and children's health care services). The facility based patient registers were designed to collect pre-defined datasets and indicators including age, sex, time and place. Duly completed registers enabled the research team to understand the magnitude of the health problems, health service utilisation rates and their subsequent results. In addition, patient's files and hospital registers were used to obtain data on admission, diagnosis, complications and type of treatment provided.

Furthermore, accounts records were also used alongside HMIS data to extract information on monthly invoices sent to district health offices. Apart from the monetary value to be paid, the

invoices included information on the number of people treated, their health problem and transport for referrals. This information was necessary in understanding the financial resources involved and how this has changed over time. The perspectives of the various stakeholders and information from the reviewed documents as presented here provided insights on the benefits and challenges posed by SLA contractual arrangements. These have been analysed, interpreted and summarised in Table 5.1.

**Table 5.1: Informants and documents reporting benefits and challenges from SLA**

<b>Informant type</b>	<b>Benefits</b>	<b>Challenges</b>
<b>CHAM</b> <ul style="list-style-type: none"> <li>• Secretariat</li> <li>• Facility managers</li> <li>• Health workers</li> </ul>	<ul style="list-style-type: none"> <li>• Increased resources to reach out to more people</li> <li>• Timely effective interventions since the fee barrier is removed for the patients reducing mortality rates and costs of treating complicated cases</li> <li>• Costs reduction and improved cash projections and flow</li> <li>• Decreased number of debts due to unpaid user charges</li> <li>• Increased opportunities for skills strengthening since included in DIP training plans</li> </ul>	<ul style="list-style-type: none"> <li>• Quality of services compromised due to high patient burden in relation to available resources</li> <li>• SLA costs are not fully recovered</li> <li>• High burn out rates of staff due to staff shortages</li> <li>• Increased pressure on equipment and infrastructure</li> <li>• Poor patient satisfaction</li> <li>• Loss of good image and reputation of quality of services</li> <li>• Increased staff demotivation and turnover</li> <li>• Vulnerable to changes in commitment from the government side because depends on personalities of DHOs</li> <li>• Untimely reimbursements that can tie up resources and affect operations</li> <li>• Abuse of the system by the communities (people lying about where they come from and using false documentation)</li> </ul>
<b>Ministry of Health</b> <ul style="list-style-type: none"> <li>• Headquarters representative</li> <li>• Zone officers</li> <li>• DHMT</li> </ul>	<ul style="list-style-type: none"> <li>• Decongestion of public health facilities</li> <li>• Improved coverage of EHP services especially MNH though difficult to measure the quality of services</li> <li>• Complementarity of services has improved</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Politicization of SLAs and disempowering of DHOs</li> <li>• Because of weak government structures, perceptions that CHAM has lost track of actual service provision and focuses on SLAs as an income generating activity</li> <li>• The SLAs subject to abuse by CHAM and the communities</li> <li>• Increasing costs from CHAM beyond DHO's budget</li> </ul>
<b>Clients/patients</b>	<ul style="list-style-type: none"> <li>• Increased accessibility and utilisation of CHAM facilities</li> <li>• Better service and care</li> <li>• Complications diagnosed earlier</li> </ul>	<ul style="list-style-type: none"> <li>• Misunderstandings of what services are covered by the SLA</li> <li>• Abuse of the SLA system by people from outside the catchment area</li> </ul>

Source: Constructed by author based on informants' perspectives and document reviews

## 5.8 Case studies

In this section the thesis will give, for each case study site, a brief background of the facility, followed by a description of the interventions covered, contractual arrangements, monitoring arrangements, results and a discussion of the main SLA experiences. The discussion will focus on the implications of SLA for the facility's resources and outcomes.

### 5.8.1 Case study site A

**Background-** Case study site A has been providing health care services in the district for over 50 years; it started its operations before the government built a district hospital. When the government eventually built a district hospital it was located 10 kilometres away from site A. This resulted in an overlap of the two healthcare facilities' catchment areas.

**Description of SLA-** the SLA covers maternal and inpatient child health services. Maternal health services include all health care services related to pregnancy while child health only covers children that have been admitted to the hospital (inpatients only). Children who are treated as outpatients are required to pay the normal user fees that the facility charges.

**Contracting arrangements:** The MoH through the district health office signed a contract with the facility based on previous interactions, without following some guidelines as stipulated in the framework for SLAs. In particular the selection criteria which stipulate that SLAs should be implemented when there is unmet need for the services in the catchment population, for instance, when there are shortfalls in government provision, were not followed. The proximity of the facility with a functional government district hospital attests to the contravention of the guidelines. The contract was for one year, renewable subject to continuing need and good performance by the provider.

#### **Monitoring approach**

According to the SLA contract, the monitoring method is based on the utilisation of the contracted services before and after the SLA was introduced. The facility is required to provide all the utilisation data through HMIS and monthly reports to DHO. The DHO in turn is supposed to verify the information provided to ensure that the facility is meeting its contractual requirements. The SLA contract further indicates that the zonal supervisor shall



carry out routine checks on the performance of the agreement as part of the district supervision visits. Such supervisory visits will include at least one biannual visit to the health facility covered in the agreement. However, members of the management team at the facility alleged that the verification process through monitoring and evaluation mechanisms by DHOs and routine visits by the zone rarely take place as stipulated in the contract.

## **Results**

Figure 5.3 shows the utilisation of maternal and child health service before and after SLAs were introduced at the facility. The vertical axis indicates the number of people who utilised maternal and child health services, while the horizontal axis indicates months from January 2005 to July 2011. The study used a six month moving average to show underlying trend and reduce the noise of short term fluctuation.

The data as presented in this figure, suggests that utilisation of both maternal and child health services have increased with the introduction of the SLA. The drop in maternal and child utilisation in the 57<sup>th</sup> and 71<sup>st</sup> months were due to drug stock out, following from non-payment of SLA invoices by the DHO. Despite the seeming SLA causal effect, it is difficult to wholly attribute the increase in utilisation to SLAs, as there were related policy interventions that were implemented at the same time as SLA, such as EHRP (which included training of more health personnel and salary top ups for health personnel) which may have contributed to the increase in utilisation.

**Figure 5.3 Utilization of maternal and child health services under SLA (6 month moving average)**

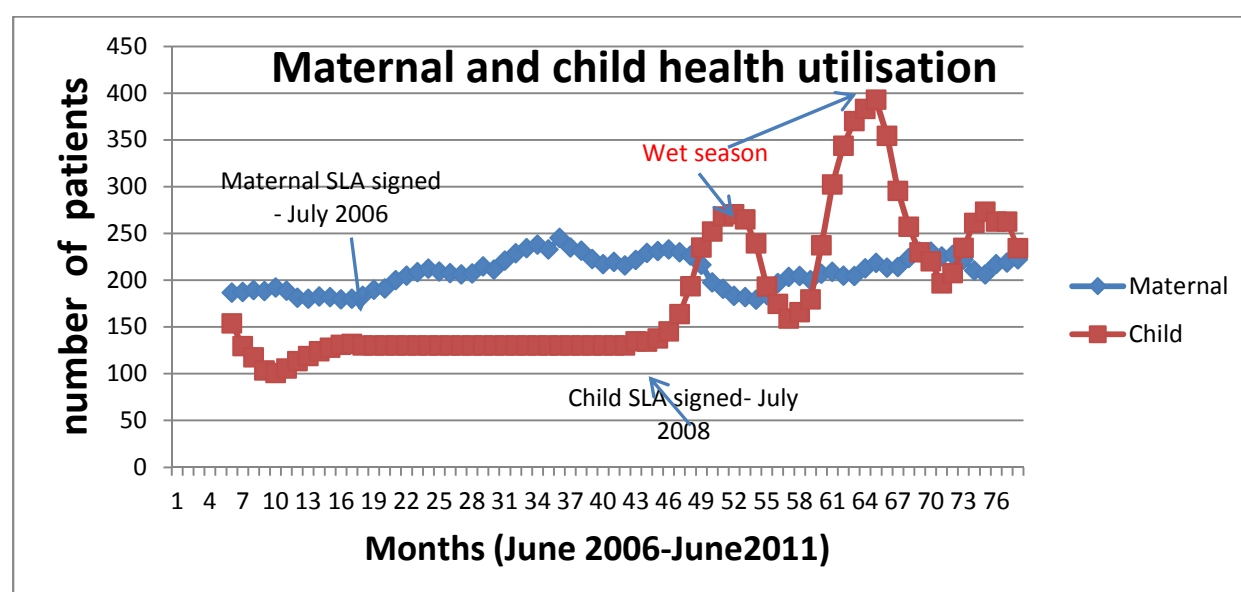
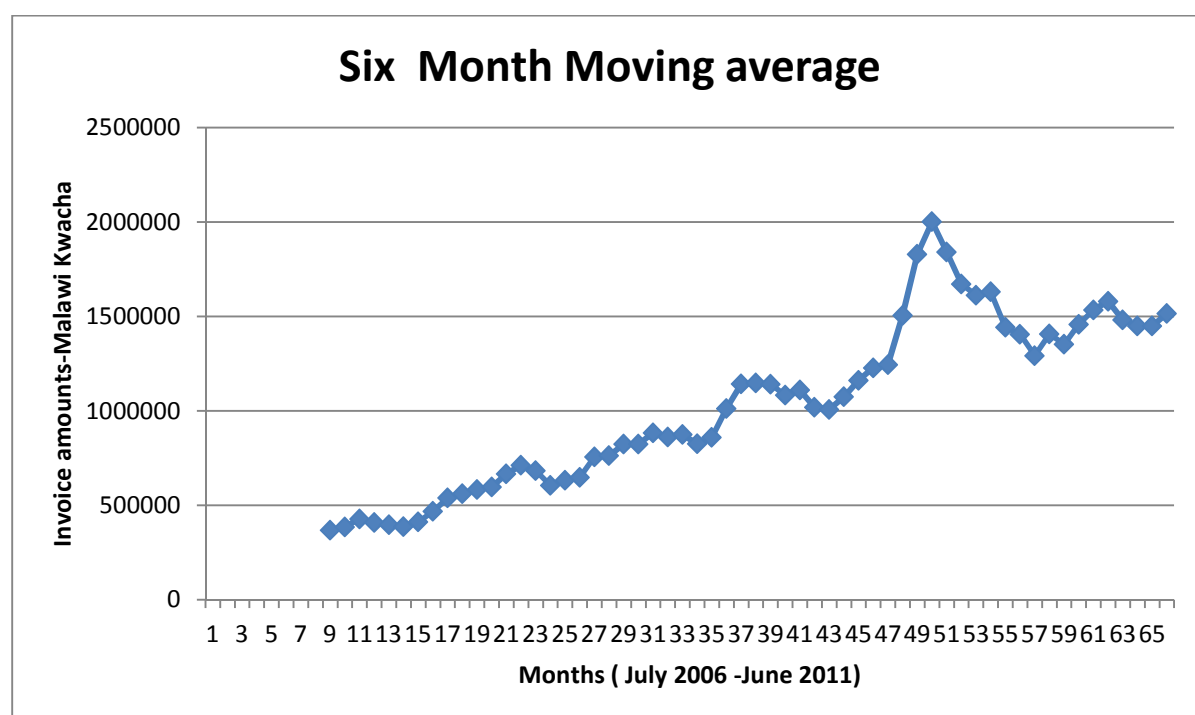


Figure 5.4 shows the value of the monthly bill sent to the DHO for the cost of providing health care services by the facility. The price charged is supposed to comprise all input costs excluding labour as this is covered by salaries which the government provides to all CHAM facilities.

The figure shows that, over time the monthly SLA bills have increased, partly due to increase in input prices such as drugs, medical supplies and the use of locum staff, this is further complicated by the rising utilisation figures particularly for child health services during the wet season, raising concerns that the government might not be able to honour invoices or negotiate payment terms, as the SLA bill presented by the facility has become larger than the DHO's budget for SLA. The small increase in the utilisation of contracted services can partly be explained by the overlapping of catchment areas, suggesting that there is duplication of services and people can choose to go to either government or CHAM facility.

**Figure 5.4 Monthly SLA bills to DHO July 2006 to June 2011**



Over the period in which the invoice data were extracted, inflation rose significantly. Since the value of kwacha decreased each month, the invoice amount could not depict a realistic picture of the prices of inputs such as drugs and medical supplies. To get a more accurate understanding we converted the entire data series to constant 2006 Malawi Kwacha using

general consumer price index (CPI) data sourced from the Malawi National Statistics office. In addition, three month moving averages were calculated to show underlying trends and reduce the noise of short term fluctuations. Figure 5.4 illustrates that the invoiced amount increased steadily but shot up dramatically before reverting to the underlying trend. The peak in the graph is thought to be caused by CHAM facilities buying drugs and other medical supplies from private providers who charge two to three times more than what the central medical store, the recommended supplier, would charge. Some facilities succeeded in passing on the increase in price to the government. The invoice amount came back to normal trend after government advised the facility that it will reimburse them using SLA guide prices which are based on central medical store price list.

## **Discussion**

Despite the modest improvement in utilisation that the facility has achieved, there are challenges that the facility is encountering due to SLA. The capacity in terms of infrastructure and health workers is constrained predominantly during the wet season when there is a surge in diarrhoea and malaria cases particularly for child health service as depicted by peaks in figure 5.3. In addition, there are contentious issues concerning renewal of contract, delayed SLA payments and revision of prices. During the case study visit, the hospital was discussing with government the possibility of revising the unit prices of various inputs used in the provision of services covered by SLA. The hospital stated that using the current price structure they have to subsidise the provision of SLA services using resources which were planned for other activities. This they said was affecting other healthcare services that the facility provides.

The contract between the facility and DHO had a clause stipulating that it could be renewed subject to some performance indicators, but at the time of this study, SLA services were being provided despite the contract having expired for over 8 months. The facility was therefore trying to persuade the government to renew the contract; as the facility would have no legal right to claim payment from government when the contract had expired. Similarly, delayed payments are affecting the facility in that it is not able to get extra staff through the locum scheme and pay for drugs and medical supplies. They reported that sometimes payment problems have forced them to use resources meant for other activities, affecting the beneficiaries of the postponed activities, such as outreach programs.

Apart from the direct costs involved in the provision of SLA services, the manager also expressed concerns about the cost of time spent meeting various government agencies concerning SLA and the extra workload of compiling reports as well as data on the operation of SLA. They were concerned that some of the meetings take away essential staff from their work stations, affecting the provision of health care services at the facility.

### 5.8.2 Case study site B

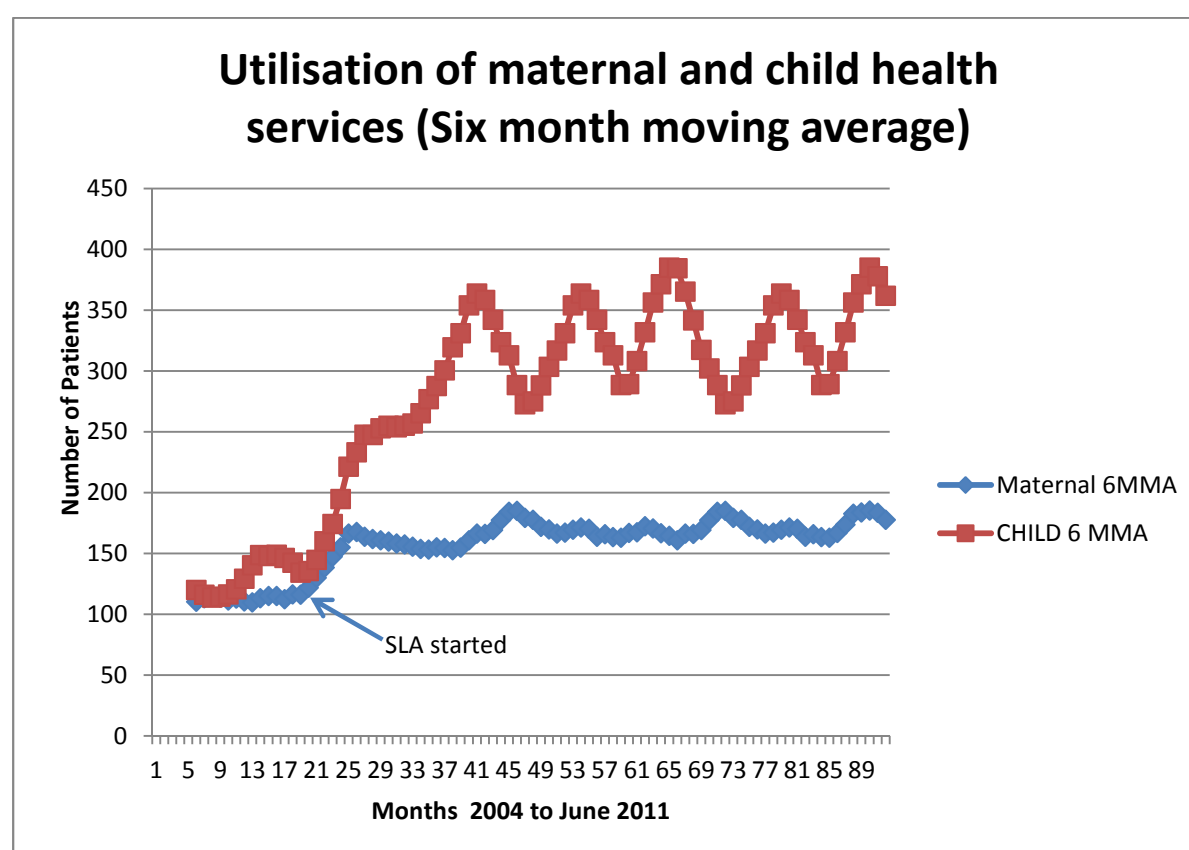
**Background-** Case study site B is a 200 bed hospital that serves a catchment area of about 500,000 people. On average, 6500 inpatients and 30000 outpatients are treated at the facility annually. The facility was designated a district hospital following a decree by a former president to turn the area where the facility is located into an autonomous district. Since the newly formed district had no district hospital, and patients from the district were taken to other district hospitals often at a higher cost to government as well as the patient and guardian, the government designated the facility a district hospital in order to address some of the challenges outlined above. Following district hospital status, the facility is used as a referral hospital for all smaller facilities located within its catchment area.

**Description of SLA intervention** -As a district hospital, the SLA contract between the DHO and the facility is considered to be comprehensive, meaning that it covers all EHP interventions as government district hospitals. This is different from SLA contracts in other CHAM facilities that only cover one or two elements of the EHP, particularly maternal or child health services. However, despite being designated a district hospital, people who access health services at the facility pay user charges or get a referral letter from a government health centre.

**Contracting arrangement-** The MoH through the zone office in conjunction with the district health office signed a contract with the facility based on previous interactions with the facility and because it was, and still is the only facility of its size in the area. The contract was in accordance with SLA guidelines and as stipulated in the framework for SLAs, in particular the selection criteria which stipulate that SLAs should be implemented when there is unmet need. The contract was for one year, renewable subject to continuing need and good performance by the provider.

**Monitoring approach-** According to the SLA contract, the evaluation method is based on the utilisation of services by patients who have been referred to the facility from catchment health facilities. The facility is required to provide all the utilisation data through HMIS and monthly reports to DHO. The DHO is supposed to verify the information provided to ensure that the facility is meeting its contractual requirements. The SLA contract further indicates that the zonal supervisor shall carry out routine checks on the performance of the agreement as part of the district supervision visits. Such supervisory visits will include at least biannual visit to the health facility covered in the agreement. However, members of the management team at the facility alleged that the verification process through monitoring and evaluation mechanisms by DHOs and routine visits by the zone rarely take place as stipulated in the contract.

**Figure 5.5 Utilisation of maternal and child health services**

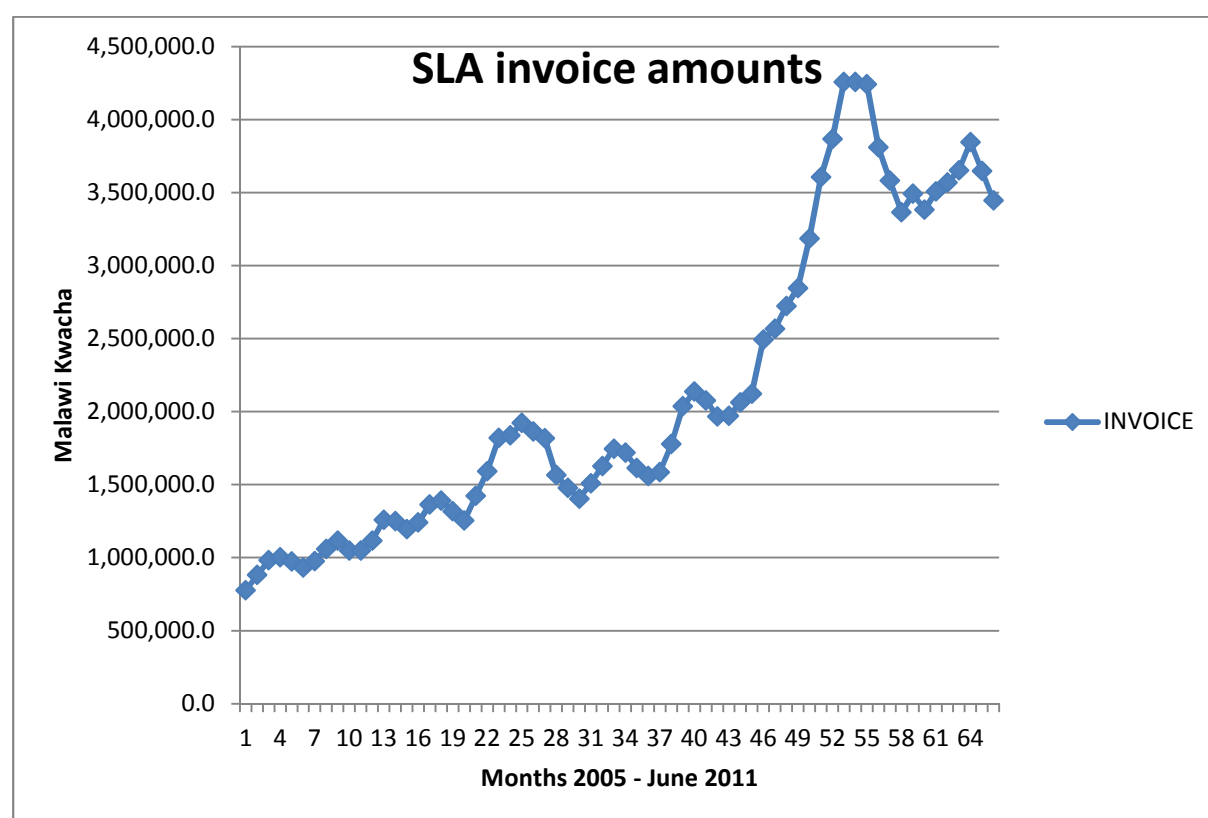


## Results

Figure 5.5 show the utilisation of maternal and child health service before and after SLAs were introduced at the facility. The vertical axis indicates the number of people who utilised

maternal and child health services, while the horizontal axis indicates months from January 2005 to July 2011. The study used a six month moving average to show underlying trend and reduce the noise of short term fluctuation. The data as presented in this figure show that utilisation of both maternal and child health services have increased, and this corresponds with the introduction of the SLA. However, just like in case study A, the increase in utilisation may not be wholly attributable to SLAs.

**Figure 5.6: SLA bill to DHO from August 2006 to June 2011**



In figure 5.6, the vertical axis shows the values of the monthly bill sent by the facility to the DHO for providing health care services, while the horizontal axis shows time in months before and after SLAs were signed.

## Discussion

Despite being designated a district/referral hospital and the modest improvement in utilisation that the facility has achieved, there are challenges that the facility is encountering due to SLA. The removal of the user fees through SLA has resulted in many people utilising services, a development that has strained the capacity of the facility in terms of infrastructure such as theatre and wards as well as qualified health personnel. This is particularly so during

the wet season when there is a surge in diarrhoea and malaria cases in particular for child health services as depicted by peaks in figure 5.5.

Similarly, considering that the facility still imposes user fees for all health care services if there is no referral letter, some people who cannot afford to pay user charges for health care services, walk long distances to get to government health centres to obtain the referral letter and then go to the facility for treatment. The distance that people travel or walk and related costs to get the referral letter act as a barrier to accessing health care by some people.

In addition, there are contentious issues concerning renewal of the contract, delayed SLA payments and revision of prices. During the case study visit, the hospital was only accepting maternal referrals on humanitarian grounds, as it was discussing with government the possibility of revising the unit prices of various inputs used in the provision of services covered by SLA. The hospital stated that using the current price structure they have to subsidise the provision of SLA services using resources which were planned for other activities. This they said was affecting other healthcare services that the facility provides. Similarly, delayed payments are affecting the facility in that it is not able to get extra staff through the locum scheme and pay for drugs and medical supplies. The managers claimed that sometimes payment problems have forced them to use resources meant for other activities, affecting the beneficiaries of the postponed activities, such as outreach programs. Furthermore, at the time of this study, SLA services were being provided despite the contract having expired for over a year. The facility managers were therefore trying to persuade the government to renew the contract.

Apart from the direct costs involved in the provision of SLA services, the managers also expressed concerns about the cost of overheads such as utility bills which are not considered by government despite the increase in the number of people utilising the services. In addition, the managers pointed out that SLA were costly to them due to the time spent meeting various government agencies and the extra workload of compiling reports as well as data on the operation of SLA. They were concerned that some of the meetings take away essential staff from their work stations, affecting the provision of health care services at the facility.

### 5.8.3 Case study site C

**Background-** Case study site C is a health centre operating under a mission hospital in the southern region. The health centre is located 35 kilometres away from the district health hospital and caters for a population of 50,000 inhabitants.

#### Description of SLA intervention

Unlike case study site A and B, SLA in case study site C covers maternal health care services only, in particular, antenatal and maternity deliveries. Complicated cases are referred to the district hospital as the health centre is nearer the district hospital than the mission hospital that it is under.

#### Results

Figure 5.7 shows the utilisation of antenatal and maternity delivery services before and after SLAs were introduced at the health centre. The vertical and horizontal axes are similar to case study site A and B. The utilisation data as depicted in figure 5.7 suggest that SLA has improved the utilisation of both maternity and antenatal health services and that the increase in utilisation of antenatal and maternal services mirror each other at this facility.

**Figure 5.7: Utilisation of Maternal services**

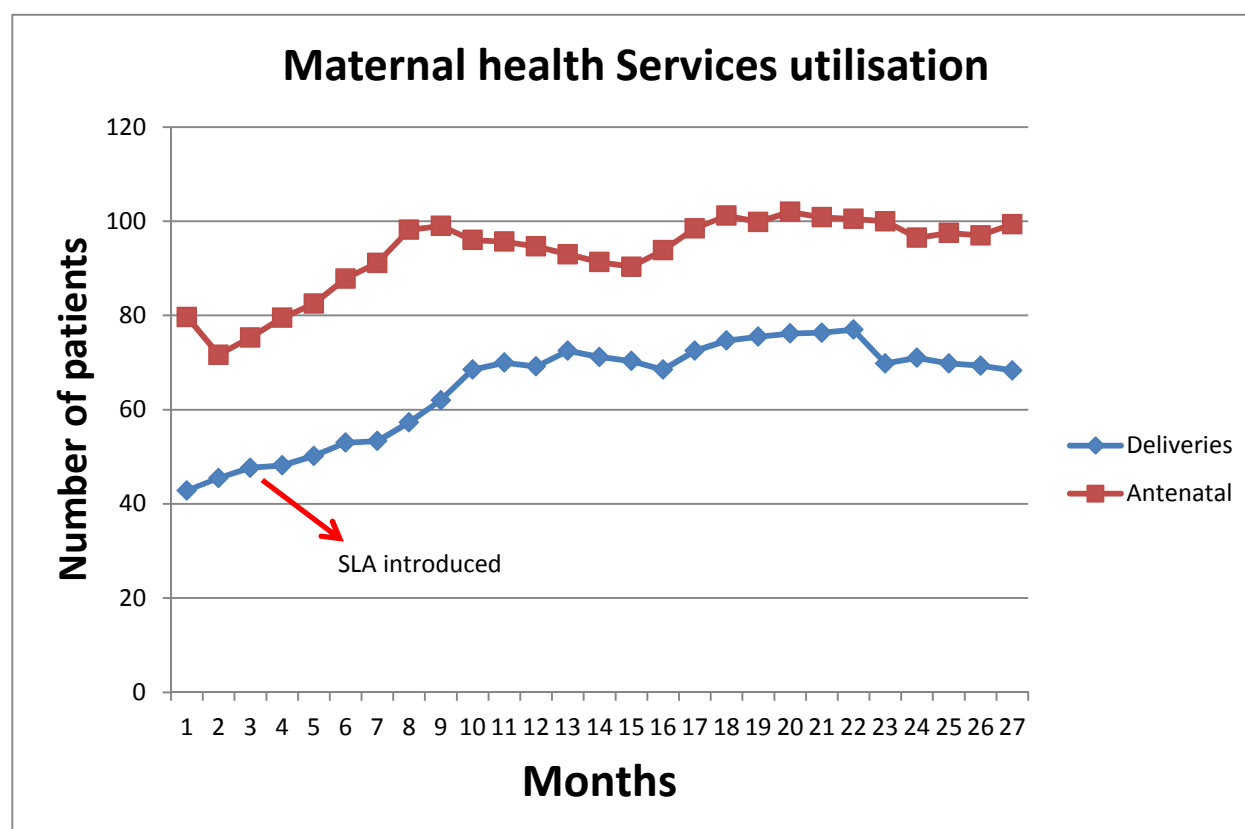
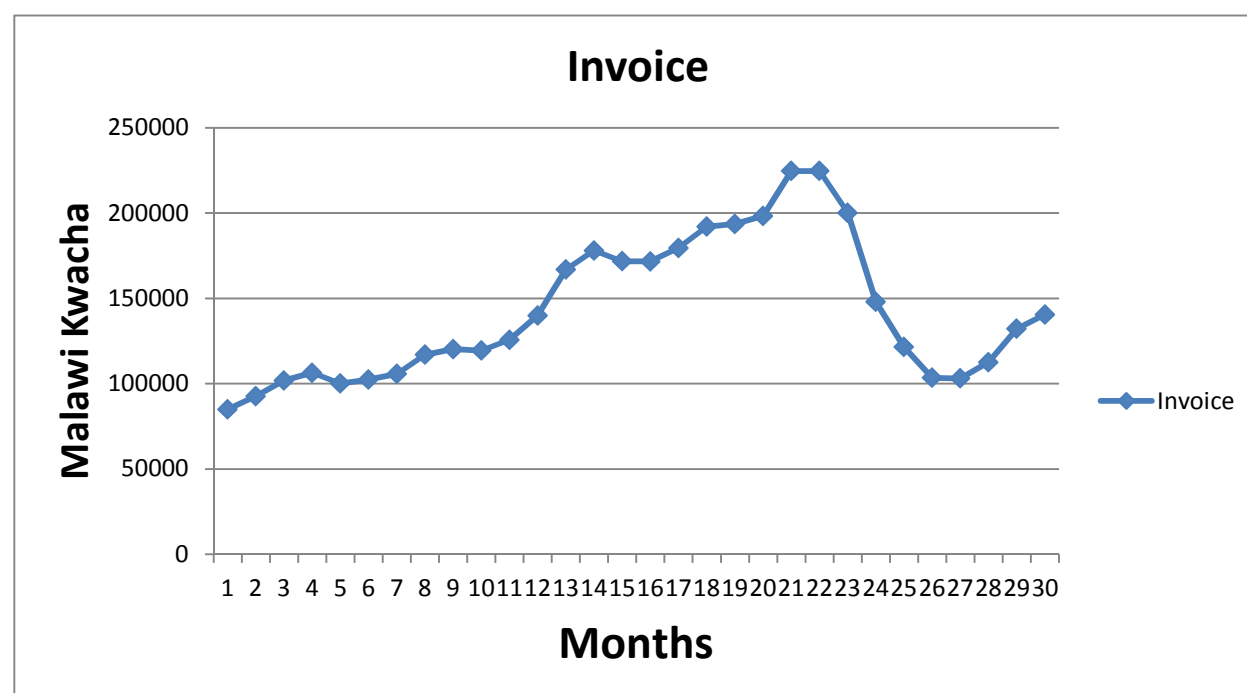




Figure 5.8 illustrates that over time, the monthly SLA bills were steadily increasing up to month 20 when they decreased sharply before starting to go up again in month 27. The managers claimed that the increase was due to increase in input prices such as drugs and medical supplies, and the high rate of inflation which was driven by the devaluation of the Malawi kwacha during this period. The decline in the invoice amount is thought to be due to government renegotiating with the mission hospital to procure drugs and medical supplies from the central medical stores which has better tariffs than the private suppliers.

**Figure 5.8: Monthly invoices to DHO**



## Discussion

Despite being able to improve utilisation of antenatal and maternity delivery services in the area, the facility has capacity challenges that may have implications for the quality of health care services provided. First, the facility has few qualified health personnel, for instance, there is only one midwife to cater for all women coming for deliveries at the health centre. Some unskilled health workers alleged that patients face long waits before they are attended and that some deliveries are attended by unskilled health workers. Second, there is no proper equipment for conducting basic medical procedures at a health centre level. These two factors may potentially explain why the utilisation of both antenatal and maternal services is tailing off, due to pregnant women's perceptions of low quality service provided by the facility.

#### 5.8.4 Case study site D

**Background-** Study site D is located in a remote district of the central region and caters for a catchment area with a population of 56,000. The facility first signed the SLA in 2006 after a pilot study on contracting out was successfully completed at the facility.

#### Description of SLA intervention

The first SLA at the facility covered maternal health services: antenatal and maternity deliveries. The SLA was later revised to cover both maternal and child health services. However, in September 2010, due to a large bill that the government had delayed to settle, the facility suspended the child health services, such that SLA based exemptions by the hospital are only for maternal services. The contracting arrangement and monitoring approach are similar to case study sites A, B and C.

#### Results

Figure 5.9 illustrates that after the introduction of SLA, the utilisation of maternal health services started to increase. This increase in utilisation is thought to have encouraged the government to extend the SLA at the facility to include child health care services.

**Figure 5.9 Utilization of maternal health services**

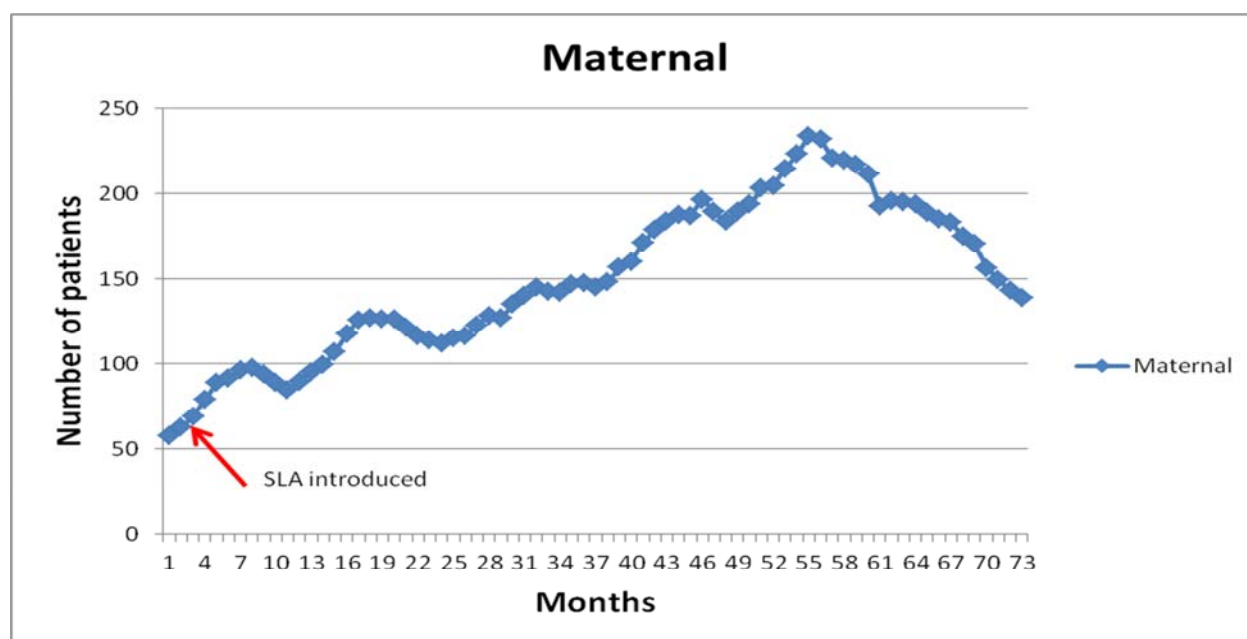
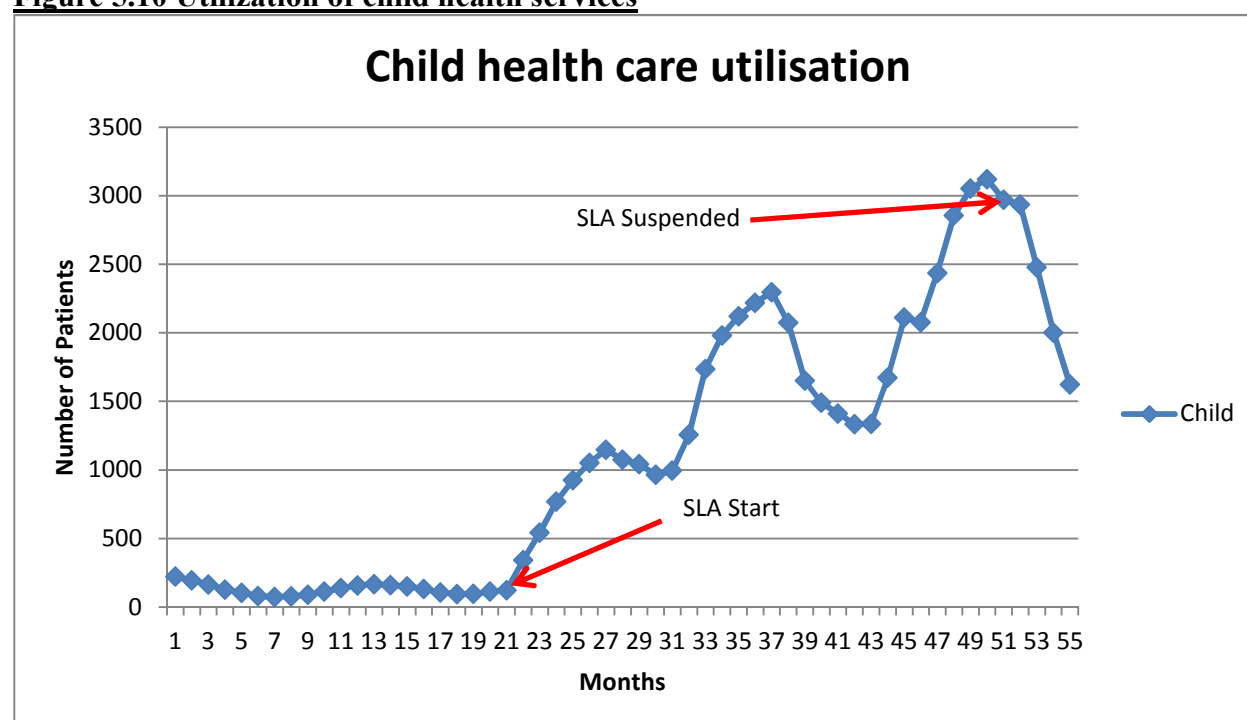


Figure 5.10 shows that when child health services were included in the SLA the number of children coming for treatment at the facility rose by over 200% in the first year as compared to the increase in maternal health utilisation which only rose by 67% in the first year.

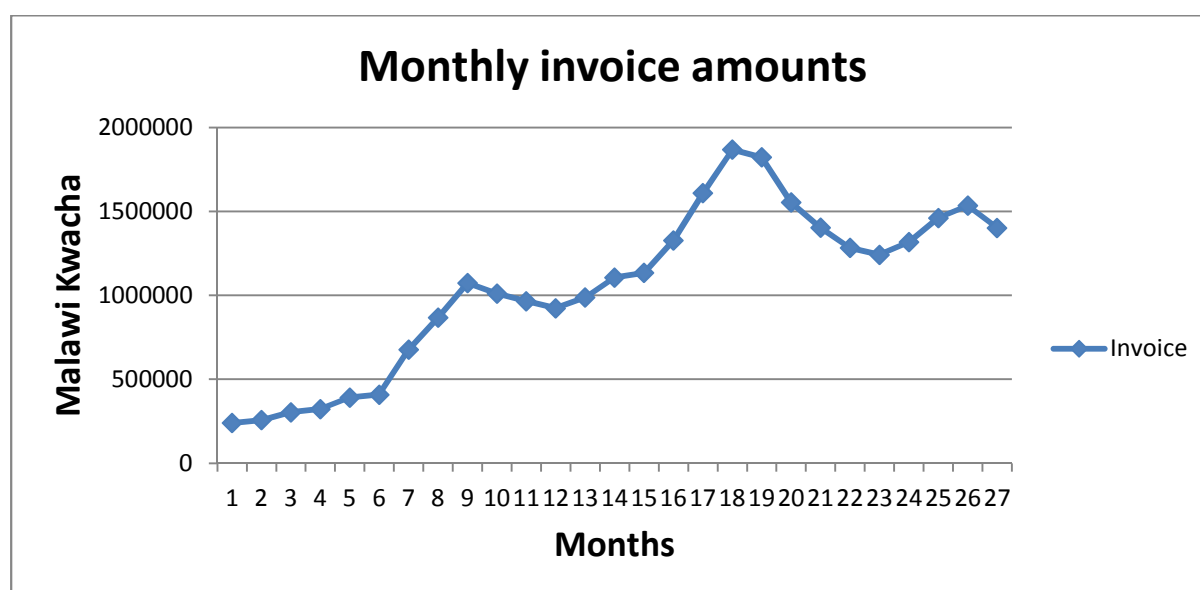
Unlike maternal health, the increase in utilization of child health services due to SLA affected the bed occupancy level, staffing, infrastructure requirements and procurement of drugs as well as other medical supplies. The informant claimed that due to the challenges brought by increased utilisation of child health services, maternal utilisation started to decline at the facility, as women started using other health care facilities where they would get better services, while others reverted back to the traditional birth attendants. In addition, the increase in utilisation of child health services caused the monthly invoice amount to increase considerably as depicted in figure 5.11.

**Figure 5.10 Utilization of child health services**



Overtime, the amount of money that the DHO owed the hospital accumulated to over MK12 million and at this point the hospital was no longer able to function normally without payments from government. The hospital therefore, suspended child SLA pending payment from government, reflected in the sharp fall in the utilisation of child health services in figure 5.10.

**Figure 5.11: SLA monthly bill submitted to DHO**



### Discussion

Despite the increase in utilisation of both maternal and child health care services, there are challenges that the facility has encountered due to SLA. The capacity of the facility in terms of finance, health workers and infrastructure has been strained. In addition, the increase in utilisation of maternal and child health care services had caused the hospital to increase expenditure on drugs and medical supplies, and triggered the need for extra health workers and physical infrastructure such as extra wards.

Due to unpaid invoices of over K12 million at the time of study, the hospital claimed that it could not operate efficiently at that point and discontinued the child health component of the SLA pending payment but continued with the maternal component. The informant claimed that before child health SLA started, there were high child fatalities at the facility, owing to delays in seeking health care due to user charges. The informant was concerned with the impact of the suspension of child health SLA, and alleged that when the SLA for child health was in operation the child mortality rate in the catchment area reduced, but may have increased again since its suspension.

#### 5.8.5 Case study site E

**Background-** Case study site E is a health centre operating under a Mission hospital run by the Presbyterian Church in the northern region. SLA was first signed with the Mission hospital and later extended to the health centre in 2006.

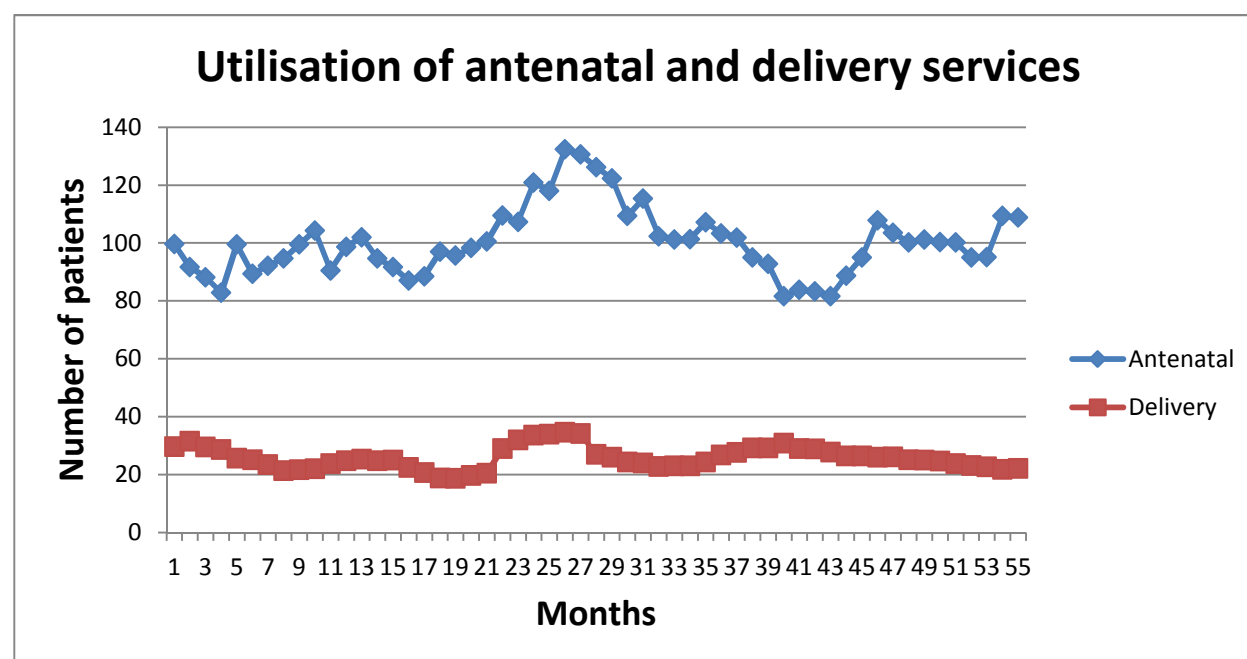
## Description of SLA intervention

The SLA here covers maternal health care services only. Maternal health includes all health care services related to pregnant women as described earlier. Difficult maternity cases are referred to the mission hospital where they have better equipment and more qualified health care personnel. The contracting arrangement and monitoring approach are similar to case study sites A, B, C and D as explained earlier.

## Results

The data on the utilisation of antenatal and delivery services as depicted in figure 5.12 illustrates that there is no noticeable change in the utilisation of delivery services after the introduction of SLA at the facility. However, the data indicate that there is a small increase in the number of women utilising antenatal services after SLA. This suggests that pregnant mothers are utilising antenatal clinic services at the facility, but choose not to deliver at the facility.

**Figure 5.12: Utilisation of antenatal and maternity delivery services**



## Comments

Monthly financial data specific to the health centre was not available as the health centre is considered as part of the mission hospital. The informant indicated that they consolidate data

from the hospital and the health centre, and send one invoice to the DHO. Due to the financial recording system that they use at the hospital and the absence of key personnel in the account section, it was not possible to extract financial data specifically for the health centre during the study visit. However, given that financial information for the other study sites is available, and that these facilities operate in similar settings, we would expect the financial information for this health centre to show similar trends.

Like most of the case study sites, the facility is poorly resourced in terms of health workers, equipment and transport, for instance, there is only one midwife to cater for all women coming for deliveries at the health centre. Some unskilled health workers alleged that patients face long waits before they are attended and that some deliveries are attended by unskilled health workers. This raises concern about the quality of maternal services provided by the facility which may affect access and equity through their link with quality as explained earlier.

**Table 5.2 Themes emanating from informant perspectives and case studies**

Interview extracts	Condensed meanings	Theme
<p><i>“ Sometimes unskilled health workers are the ones who deliver mothers at the hospital”</i></p> <p><i>“our experience in costing SLA has been like one blind person leading the other, we did not include items like gloves, cotton wool delivery packs, etc. in the initial costing with the DHO”,</i></p> <p><i>“The children’s ward was very small, but the introduction of SLA coincided with a project to extend the capacity of the ward”</i></p>	<ul style="list-style-type: none"> <li>✓ Limited infrastructure</li> <li>✓ Inadequate number of health workers</li> <li>✓ Limited contracting knowledge</li> </ul>	Capacity
<p><i>“MoH did not define what exactly SLA is all about- are they outsourcing to CHAM or is it supporting CHAM, or is it a mixture of both? Clarity of this could assist in improving a lot of things on the ground”</i></p>	<ul style="list-style-type: none"> <li>✓ poor public decision making</li> <li>✓ poor coordination of policy activities</li> <li>✓ Growing opposition of SLA by some public sector players</li> </ul>	Policy inconsistency

<p><i>“The government should just build their own hospitals and let CHAM continue with their business”</i></p> <p><i>“CHAM facilities are treating SLA as an income generating activity”</i></p> <p><i>“DHO pursue activities that benefit them directly”</i></p>	<ul style="list-style-type: none"> <li>✓ goals of Government and CHAM different</li> <li>✓ motives of Government agents varying at different level</li> <li>✓ Motives of various stakeholders in CHAM are different e.g. proprietors, board members, management, physicians and health workers</li> </ul>	Diverging objective functions
<p><i>“...MoH health Zone supervisor expressed frustration about the preferential treatment that DHOs give to some CHAM facilities..” (GTZ, 2009).</i></p> <p><i>“There is no clear definition of roles and responsibility on SLA by MoH headquarters, the ZHSO and DHO” (GTZ, 2009).</i></p>	<ul style="list-style-type: none"> <li>✓ involvement of various agencies and levels of government</li> <li>✓ Levels of authority in CHAM from proprietors, board members, management, physicians and health workers</li> </ul>	Multiple agency relations
<p><i>“There are times we wish we had come out of SLA arrangements but it is difficult to do so due to the politics surrounding the arrangement”</i></p>	<ul style="list-style-type: none"> <li>✓ By-passing DHO</li> <li>✓ Concern on losing government support</li> </ul>	Political interference
<p><i>“CHAM should understand what government is trying to change not just in the interim but also in the future because those leading the government now can change. Will the future government continue with SLA?”</i></p>	<ul style="list-style-type: none"> <li>✓ donors involvement in SLA</li> <li>✓ change of government</li> </ul>	Sustainability
<p><i>“The hospital management has been to the district and zone office several times to discuss the payment issue,”</i></p> <p><i>“CHAM has called for a meeting with government to negotiate prices and other conditions on SLA but government does not take CHAM serious on SLA”</i></p>	<ul style="list-style-type: none"> <li>✓ renegotiation of prices,</li> <li>✓ contract renewal,</li> <li>✓ chasing payments</li> </ul>	Transaction costs
<p><i>“lack of administrative and legal processes to support the implementation of SLA”</i></p>	<ul style="list-style-type: none"> <li>✓ legislation change</li> <li>✓ non functional regulatory body</li> </ul>	Institutional framework

## 5.9 Conclusion

This chapter has described the data; particularly outlining the perspectives of different informants of SLA in as far as health care provision is concerned. The perspectives of the research informants have shed some light on the implications of SLA for access, equity, quality and efficiency in the delivery of health care services through CHAM facilities. Most respondents considered that the SLA is a good mechanism, enabling wider access to services. However, they pointed out a number of challenges that may be impinging on the performance of SLAs.

The chapter has also described the five case studies, including data on types of services provided, utilization trends, costs of inputs and other costs not directly related to health care service provision, such as the costs of SLA renegotiation meetings. A number of themes have emerged from the analysis of various perspectives as presented by key informants and case studies. These themes are summarized in Table 5.2, and they provide the framework for the discussion in the subsequent chapters. The next chapter will discuss the objective functions of the main stakeholders of SLA, focusing on their stated and revealed objective functions and how these objectives affected the provision of health care under SLAs.



## **Chapter 6: Objectives of government, development partners and CHAM facilities**

### **6.0 Introduction**

This chapter discusses the objective functions of stakeholders, in particular the Ministry of health, CHAM facilities and development partners (DPs) in as far as SLA is concerned. The discussion will focus on both stated objectives as documented in SLA contract documents, policies, reports and meetings as well as those revealed through observing the behaviour of government agencies, DPs and CHAM facilities. The chapter will first provide a brief description of the link between motives, incentives and objective functions, followed by an overview of not-for-profit organisations, government agency and DP objective functions in general. The subsequent sections will explore revealed objective functions in SLA contractual relationships. The explanation of revealed objective functions is presented through examples of observed behaviour and the actions of CHAM facilities, DP agencies and government agencies representing the Ministry of Health. Illustrations of behaviours and actions as well as responses as shown in the previous chapter are used here.

### **6.1 Motives, incentives and objectives**

Motives drive the initiation, direction, intensity and persistence of behaviour. In general, motives are normally used to mean the specific reasons for performing a specific action, particular goal or objective. Any behaviour has some motive; however, the principle motives can be classified as power, affiliation and achievement. The power motive entails the wish to have impact on other people by affecting their behaviour and emotions, the affiliation motive involves the concern to establish, maintain and re-establish relationships with others, while the achievement motive is characterized by concern for competition, some unique standard of excellence or realization (Hofer and Busch, 2011).

Motives can be at different levels; individual, societal and organizational. The three levels of motives interact among themselves, for instance, the development of organizational motives can arise from the interaction of the proprietor's and individual members' beliefs and values as well as the external environment. The proprietor may have the greatest influence on the organizational motive in its earliest stages. This influence may be weakened as the organization grows and develops. A general motive may emerge but sub motives may also be

apparent. These may emerge due to the heterogeneous nature of the aims and goals of disparate groups and individuals working within and outside the organization.

Organizational motive is therefore synonymous with the actions and attitudes of people in organizations, as it entails human motives in organizational settings, how human motives interact with the organization and the organization itself. For instance, we can study individual motives (Such as the motives of a CHAM facility proprietor or one of its managers) without explicitly considering the organization. But because the organization influences and is influenced by the individual, we cannot fully understand the individual's motives in relation to the organization without knowing something about the organization. Similarly, we cannot understand the motives of the organization without focusing specifically on the key individuals within it.

Incentives on the other hand are external measures that are designed and established to influence behaviour of individuals, groups or organizations to achieve a particular objective. Contracting out is based on incentives and it derives its strength from being able to predict how individuals change their behaviour in response to change in incentives. By neglecting incentives one may fail to understand the levels and changes in behaviour and as a consequence may even fail to understand the effect of economic incentives on behaviour (Gibbons, 1998). Dixit (2002) has argued that incentives have beneficial effects in some situations and for some principals, but generate unintended outcomes with negative consequences in other circumstances and caution that incentives need selective application to specific agencies or tasks.

In a principal agency relationship, the principal uses incentives to motivate the agent's actions towards the attainment of the contractual outcome or objective. Objective in this discussion entails a specific result that an individual or organisation aims to achieve within timeframe and with the available resources. In general, objectives are explicitly given by the individuals or organisations concerned (stated objectives). However, in some instance, the objectives are constructed by observing the behaviour of those concerned (revealed objectives). In these kinds of relations, the principal and agent have objectives that are independent, and both parties act so as to maximise their expected utility. In order for the principal to devise incentives that will motivate the agent to perform in the principal's interests, it is important for the principal to identify and understand the agent's objective,

both stated and revealed. It is thought that the understanding of objective in a contractual relationship helps the principal to predict the behaviour of the agent within the contract. In turn this understanding can help principals to design appropriate incentive mechanisms or refine existing ones to avoid perverse incentives from developing. This could potentially aid principals to achieve policy outcomes such as strengthening health systems through policies like contracting out using SLA.

### **6.1.1 Objective functions of not-for-profit organisations in general**

Private not-for-profit providers are defined primarily by the legal requirement that the surplus of revenue over expenses is not distributed to the organisation's owners or patrons- *the non-distribution constraint*. This makes the economic behaviour of these organisations potentially different from that of private for-profit providers. However, these differences have been subject to considerable debate and research. A vast body of theoretical and empirical work has emerged to describe and document how not for profit organisations behave, in particular, focusing on how they behave differently than for profit organisations. Most economic models of not-for-profit providers analyse their resource allocation choices (Arrow, 1963; Jacobs, 1974; Culyer and Jonsson 1986; Chalkley and Malcomson, 2000; Chalkley, 2006). Culyer and Jonsson (1986) have regarded not-for-profit providers as organisations with their own goals and suggest that these goals imply maximisation of the quality of inputs and outputs; or maximisation of the quantity of outputs. This implies that there are no differences between behaviour of for-profits and not-for-profits that might be expected.

While these explanations are able to reflect the altruistic characteristics often attributed to not-for-profit providers, and prove useful to understanding cost changes in the provision of health care, they are over simplified in that they do not acknowledge the existence of multiple decision makers in most not-for-profit organisations. The studies of Pauly and Reddish (1973) explicitly address the roles of multiple decision makers in not-for-profit hospitals, and argue that decision making power lies with physicians who are assumed to operate the institution as a physicians co-operative with the goal of maximising its residual income (total receipts less other costs excluding physicians' compensation). The residual income is then shared among physicians as in private-for-profit organisations. The assumption that clinicians have *de facto* control over resource allocation implies that clinicians attempt to perform the

roles of managers and entrepreneurs. The implications are that hospitals pursue cost-minimization in production.

In contrast to Pauley and Reddish (1973), McGuire (1985) point to a number of theories which emphasize the administrators as the main actor in the hospital, and imply that the influence of the clinician in the decision making process is somehow reduced or ignored. For instance, Reder (1965) has shown that in circumstances where administrators are the main actors, more focus is on quality and quantity maximizing objectives, which are related to prestige and salary. Reder's (1965) observation is similar to Lee's (1971) who argues that administrators attempt to maximize utility which is functionally related to status and prestige.

Pauley and Reddish (1973) and Harris (1977) conclude that not-for-profit providers can and often do make profit of a kind, however, it is not distributed to external claimants but is absorbed within the organisation. This suggests that not for profit providers mimic the behaviour of for profit providers when they actively maximize surplus. Thus, not for profit organisations respond to incentives similar to for profit organisations and behave like profit maximising firms (Duggan, 2002).

Similarly, Harris (1977) theory of health care provider behaviour makes no real distinction between private for profit and not-for-profit forms of organisation. He contends that both types of providers consist of two firms: a physicians' firm which demands hospital services (such as diagnostics services like laboratory and radiography) for its clients and an administration firm which supplies these services. Whatever the physicians and administrators objective functions are, both the physicians and administrators clearly comprise an important decision making group within not-for-profit health care institutions. This suggests that for profit and not-for-profit private health care providers may have objective functions which are mostly influenced by the people involved in the organisation as well as the vision of the organisation, indicating that their behaviours are not different as implied in their definitions

### **6.1.2 Objective functions of public sector agencies in general**

Like the not-for-profit private health care providers, public sector purchasers or government agencies have varied objective functions. However, unlike private providers' objectives of making profit /surplus, public sector agencies primary objective has apparently been assumed

to be the provision of public services such as health care and education for the taxpayers (citizens) at either local or central level. In general, some specific objective functions in the public sector may include those listed in table 6.1.

**Table 6.1 Objectives associated with public sector agencies**

<b>Objective</b>	<b>Public Agencies are expected to</b>
Public interest	Display an interest beyond the boundaries of their particular organization, and serve the public good
Accountability	Accept legitimacy of the political structure and be committed to implementing public policy without reference to their political views
Bureaucratic behaviour	Demonstrating characteristics of honesty, integrity, impartiality and objectivity
Loyalty	Operate within a complex set of loyalties (Including to the department, organization, profession, institution and community)
Motivation	Identify with an altruistic purpose of motivation (rewarding work that has value for the community) rather than self interest or a profit motive

Source: Adapted from Pratchett and Wingfield (1996: 641-2)

The objectives as stated in table 6.1 have traditionally been used to judge the behaviour of public sector agencies and have provided important guide points for the appropriate design and operationalization of key public sector policies. However, public choice theory (Black, 1958, Buchanan and Tullock, 1962) provides some conflicting perspectives on public sector objective functions. The theory analyses the behaviour of politicians or government officials and the behaviour of individuals who interact with government and the assumption that participants in the political or government sphere aspire to promote the common good. Thus, in the conventional public interest view, public officials are portrayed as benevolent public servants who faithfully carry out the will of the people. That is, in tending to the public's business, politicians and policy makers are supposed somehow to rise above their own concerns. Public choice theory argues that public sector policy makers may behave or act in a self-interested way for the purpose of maximizing their economic benefit (such as personal

wealth) and that, the actions may result in outcomes that conflict with the preference of the general public.

In addition, public choice theory asserts that decisions are driven by individual self-interests rather than by organizational efficiency considerations. According to this theory, Birdsall and James (1992) have argued that,

*“politicians do not seek to maximize efficiency but rather to maximize their own chances of staying in power; bureaucrats seek to maximize their budgets; and individuals use governments to augment their real income via the creation of protected market position and direct provision of services and transfers”*

(Birdsall and James, 1998, page 3)

Birdsall and James (1992) have therefore concluded that public choice politics may result in perverse, inequitable and inefficient resource allocations.

Similarly, Frant (1996) has noted that, “the interest of the citizens and politicians are not necessarily the same; politicians at times may display opportunism, and they may fail to act in the interest of the citizens. In addition, Frant (1996) point out that, we must recognize the political opportunism as a critical issue in the design of public organizations as this may lead to politicians engaging in exploitative behaviour. For instance, in pursuing their political interests politicians might use their fiscal power to promote implementation of inefficient policies (Buchanan and Tullock, 1962).

The foregoing implies that the government may state its policy objective as providing quality and affordable services, reducing inequity in the use of health care services, promoting consumption of health care services that reduces incidence of severity of infectious diseases and other conditions that harm society and ensure efficient health care spending. However, the government may not pay much attention to health related activities as stated in the objectives, but instead concentrate on activities that may improve the probabilities of those in government (politicians, technocrats and lower level managers) being voted back into office through activities such as the provision of business loans and investing in white elephant projects at the expense of health care. This has been explained by Frant (1996) as political

opportunism or the public sector version of high powered incentives. In a case like this, the revealed objective of government may be construed to be that of remaining in power.

Related to public choice theory as presented here, is interest group theory. Interest group refers to practically any voluntary association that seeks to publicly promote and create advantage for its cause. In general, interest groups are broadly placed in five categories: public, economic, public and private institutional, cause groups and non-associational groups. Economic interest groups advocate to gain economic advantage for their members; Cause groups represent a segment of the population but whose primary purpose is noneconomic and usually focused on promoting a particular cause or value e.g. religious organization; Public interests groups promote issues of general public concern ( e.g. human right and environmental); Private and public institutions interest, like other interest groups, attempt to effect policy in their favour, by advocating on behalf a particular issue of philosophy; Non-associational groups and interests includes spontaneous protest movements formed in reaction to a particular policy or event. The groups may include informal groups of citizens and officials of public as well as and private organization (Duignan, 2013).

The categories as illustrated here include corporations, charitable organizations, professional associations, trade associations, charitable organizations and civil rights groups. Interest groups influence government decisions and policy through lobbying for example by providing information to politicians. The generalized idea about interest groups is that the organized, “few” win favours from government at the expense of the unorganized “many” (Tollison, 1988)

Interest group theory of regulation and government has been in the literature of economics and political science for a long time (Olson; 1965; Stigler, 1971; Posner, 1974; Tollison, 1988). The theory helps explain the behaviour of government and its agents, for instance, by clarifying why vote and budget maximizing public officials are, in effect, constrained to make trade-offs among a variety of politically determined policies and show that public policies are mostly the result of trade-offs or compromises at the margin. This implies that no one interest group gets all that it wants in this process and that hard choices about public policy rarely get made as the state tries to favour all interest groups, leading to *policy paralysis*.

### 6.1.3 Objective functions of development partners

In general, multilateral and bilateral DPs play an important role by providing resources to various sectors of recipient low income countries in the form of foreign aid, also known as official development assistance (ODA). Foreign aid includes loans, grants and technical assistance on concessional financial terms. The objective of providing foreign aid is mostly stated as to reduce poverty and promote economic development in these low income countries. However, despite its increased use, the role of ODA for reducing poverty and promoting well-being remains controversial (Younas, 2008).

An extensive literature exists to explain DPs' objectives underlying allocation of resources in the form of aid. Studies have attempted to understand various motivations classified under DPs self-interest and recipients need (Maizel and Nissanke, 1984; Gounder, 1999; Easterly, 2007; Alesina and Dollar 2000; Tingley, 2010). In their studies, Easterly (2007) and Tingley (2010) have argued that, except when aid is allocated on the basis of altruism, even the recipient's need criteria must somehow satisfy DPs' interest. The DP interest may be built in trade, investment and security considerations. Nevertheless, DP interest may have some considerable positive externalities for some recipient countries. For instance, the trade interest of a DP country may promote growth in low income countries which are its major trading partners (Maizels and Nissanke, 1984).

To further elucidate the objectives of development partners, Easterly (2007) has argued that despite their seemingly more humanitarian intentions, DPs are rational actors who are attempting to maximize their welfare and respond to incentives accordingly. Tingley (2010) has argued that DPs objectives are comprised of self-interest factors from their countries and domestic political climate, and that aid allocation patterns play a significant role in changing the conditions and incentives faced by the recipient country, and that this change may be negative. Similarly, according to Alesina and Dollar (2000), DPs respond to self-interest variables such as, recipient colonial history, voting pattern alongside the donor in the UN congress and commercial as well as strategic interests. In addition, Alesina and Dollar (2000) have further argued that the motives of donors stem from the general rationale among donors that, aid can establish commitment, however, aid dependence in the recipient country develop as a side effect.



Furthermore, Alesina and Dollar (2000) have argued that foreign policy goals of the DPs are the most important motives for giving aid, and that some bilateral DPs try to influence multilateral institutions to support their foreign policies. The pattern of aid giving is more dictated by political and strategic considerations of the donor country than economic needs or policy performance of the recipient country (Alesina and Dollar, 2000; Martens, 2005). These non-altruistic donor behaviours are beneficial to them and are expected to dominate in aid allocation decisions.

This study was designed to understand the implications of contracting out between CHAM facilities and government agencies. This necessitated the collection of data from government and CHAM. However, after data collection was finished and, we started analysing the data, it became apparent that, we could not understand the implications of the contractual relationship between government and CHAM, in the absence of DPs, due to their major role in providing funding and technical expertise in the health sector. However, due to financial constraints, we were not able to go back and collect data from various DPs who finance health sector activities, including the SWAp basket which funds SLAs.

Oliveira Cruz (2008) concluded that the actions of some development partners in Uganda were not consistent with their stated objectives, but revealed other objectives including political and commercial objectives. Considering that Uganda and Malawi operate in similar settings and that the countries work with almost the same development partners, information on motives of the donor organization and countries as presented by Oliveira Cruz (2008) might be similar in Malawi. The study will therefore use Oliveira Cruz's (2008) findings on the motives of donors in Uganda alongside information on development partners operations in Malawi. Information from Malawi government documents, development partners' reports, independent reports and published literature is used to identify stated objectives of donors in Malawi in relation to SLAs. This information is collated with Oliveira Cruz's (2008) findings to derive some conclusions.

## **6.2 Stated objectives**

This section focuses on the motives of CHAM, government and DPs, as stated in interviews, discussions during case study visits and as documented in policy documents as well as

various reports respectively. The section covers both individual and organisational stated objectives.

### 6.2.1 Individual objectives

Government departments, DP agencies and CHAM facilities are operated by individuals who may have varying objectives, different from those of the organisation of which they are part. Some stated individual motives of CHAM representatives (such as management team and key health workers) and MoH officials at headquarters, zones and districts are presented in turn.

#### 6.2.1.1 CHAM facility representatives

This section explores the stated aims of key CHAM representatives (including secretariat officials and managers). In general, the findings of this study demonstrate that common stated motivations for participation of individuals in SLA operations are the drive to contribute towards the strengthening of health systems, and personal career development. This was generally claimed by both CHAM secretariat and CHAM facility respondents. Individuals working for CHAM expressed their willingness to make a difference in society by working with the government towards the improvement of health outcomes in their catchment area. They claimed to feel motivated to help the effort of the government in ensuring that the poor are accessing and utilising health care services. They stated an interest in seeing high maternal and child mortality rates fall. More specifically they conveyed their commitment to maternal and child health care services. For instance a respondent from a case study facility that had an SLA covering child health services but stopped due to non-payment indicated that:

*“We are concerned with the suspension of SLA health care services for under five Children, as this will increase infant mortality rate”.* (CHAM facility respondent)

Similarly, an informant from a facility that was a designated district hospital and was providing health care services to all referred patients, argued that,

*“The facility has stopped accepting all referrals from the catchment area; we are only accepting maternal referrals on humanitarian grounds”* (CHAM facility respondent)

The humanitarian ground here is linked to the religious beliefs of the proprietors who claim to derive utility from providing philanthropic health care services. CHAM informants claimed that, catholic sisters and brothers from the proprietor organisations volunteer their time and financial resources in some CHAM facilities. The informants further claimed that these sisters and brothers work extended hours in pursuit of their spiritual beliefs to help those in need of health care services. During the study period, the researcher noted a considerable involvement of sisters and brothers in key positions such as hospital administrators, accountants, matrons and pharmacy managers at various CHAM facilities. While it may seem that these individuals derive some satisfaction from the volunteering, using the principal agent model they could be construed as agents of the proprietors, assigned these roles in pursuit of the proprietor's goals.

Other motivating factors that CHAM representatives claimed included their relative autonomy in how they choose to achieve access targets in contrast with their counterparts in the public sector, giving them the opportunity to take initiative and have some control over inputs required for SLA. Further factors were the possibility of having management authority, power and seeing their participation in the health system recognised. These objectives may be comparable to those of government representatives who indicated some of their objectives as related to the rewards that accrue to them due to their involvement in successful programs. Implicit in this, is the objective to control resources as allowed in the SLA contract in contrast to using funds channelled through general and sector budget support which is argued to be governed by more bureaucratic controls.

Similarly, some respondents commented that it was motivating to be part of the decision making process in the government machinery. They appreciated their involvement to influence and change policy through technical working groups and other meetings at the ministry of health headquarters. For instance a CHAM respondent pointed out that s/he was able to secure a ventilator for a facility after meeting with government officials at the Ministry of Health. In addition, the maintenance and improvement of relationships with government was claimed to play a major role in motivating a number of respondents. Most managers stated that SLA has improved their hospital's relationship with the government and politicians who encourage their constituents to access free health care services provided by government through CHAM facilities.

### ***6.2.1.2 Government representatives***

Most government representatives claimed to be motivated by their contribution to the improvement of the health system. Informants mentioned that they want to make a difference, specifically emphasising that they would like to work towards helping the districts to increase coverage of reproductive health services. The respondents pointed out that contracting out health care provision, especially through SLA holds a promise of many benefits in Malawi toward meeting the national health objectives as outlined in the health policy document (1985-1996).

Some respondents indicated they were motivated by greater control over project resources due to the status such control offers and the benefits of controlling resources. These resources were related to the elements that enabled the implementation of activities as well as facilitated their work such as computers, telephones, vehicles, and fuel and support staff. These were seen as alternative sources of motivation in the context of low salaries and conditions of service in the public sector.

### ***6.2.1.3 Individual Donors***

Oliveira Cruz (2008) noted that similar to the motives of government officials, individuals working for DP agencies expressed their willingness to ‘make a difference’, and work towards improvements in the sector. They also felt motivated to help the state to achieve its health policies and were generally interested in development issues in Africa but also in individual countries like Uganda. These motivations were more strongly emphasized by those working in large donor country agencies such as DFID and USAID.

Other motivating factors for individuals representing donor agencies included the independent nature of their work as it allowed them to take initiatives and have some control over aid from the donor country. Additional motivations were the possibility of having management control, power and recognition in their particular role. These motives seem comparable to those of Malawi government representatives and CHAM officials who described some of their motivations as related to the rewards they accrue from being associated with a successful project; but also implicit is the link to the control of resources as allowed to the projects in contrast to sector and general budget support.

Oliveira Cruz (2008) further demonstrates that the majority of respondents had career development goals and intended to continue working in areas related to donor aid. They stated that they would like to gain further experience in different countries which could allow them the opportunity of learning different cultures and languages.

### 6.2.2 Organisational Objectives

This section reports the organisational objectives of government, DPs and CHAM facilities as presented in contract documents, policy documents, various reports and what was reported by the research respondents. Generally, there seemed to be some alignment between the objectives of CHAM and government as represented in the documentation.

#### 6.2.2.1 Organisational objectives: Government

The overall policy objective of the government in relation to the health sector as outlined in the National Health policy plan (1986-1995) is stated to be,

*“ To raise the level of health status of all Malawians by reducing the incidence of illness and occurrence of premature deaths in the population, by increasing availability of quality EHP services and increased utilisation of EHP and other health services ”* (Malawi National Health plan (1986-1995)

Similarly, the Malawi health sector strategic plan (HSSP) 2011-2016 has stated that,

*“The vision of the health sector is to achieve a state of health for all the people of Malawi that would enable them to lead a quality and productive life”* (HSSP 2011-2016).

The government states specific objectives through which to achieve the overall health sector policy objective. Some of these specific objectives are;

- Expand the range and quality of health care services for mothers and children under the age of 5
- Ensure that better quality health care is provided in all health care facilities
- Strengthen, expand and integrate health services to the general population
- Increase efficiency and equity in resource allocation

- Increase access to health care facilities and basic services
- Increase the number of trained human resources for health and distribute them efficiently and equitably.
- Collaborate and partner with other major stakeholders to strengthen the health sector
- Increase the overall resources in the health sector.

The overall stated objective as well as specific objectives of health sector policy as documented in the policy documents named above is reflected in the response of the informants. For instance, one respondent reported that the main objectives of the government through the Ministry of Health were to reduce poverty as documented in the Malawi poverty reduction strategy (MPRS), providing accessible health care services to all Malawians as outlined in the essential health package (EHP) policy and reduction of maternal and child mortality rate as targeted by the Road map for accelerating the reduction of maternal and neonatal mortality and morbidity in Malawi (2007).

The informant also claimed that the overall objective of government was to improve the health outcome of Malawians through strengthening the health system and not by focusing on time limited solutions such as short term projects. One DHMT respondent claimed that the government has some competent technical experts and that some politicians are altruistically motivated. These two groups were argued to be capable of making a difference if given the opportunity. Some informants considered that there was need for appropriate resource allocation and strong political will in order for the government to realize its health sector objectives as outlined in the documents discussed here.

In connection with increasing coverage of health care services the government also had an objective of strengthening its partnership with private sector health care providers including those who have not played a major part before. For instance one government official stated that

*“government wants to work with the private sector in order to achieve its goal of providing affordable health care to all Malawians” (MoH informant)*

An additional objective reported by some informants was that the government is committed to increasing the health workforce in the country through the increase of candidates going to institutions that train health workers and funding the expansion of such institutions. Similarly, the respondent from MoH also mentioned the intention of government to retain skilled health workers in the civil service, this they claim is backed by the current initiative in health worker salary top ups. This is one area where there is alignment between stated CHAM and government objectives in that they all identify the need to train extra health workers for the health system.

#### **6.2.2.2 Organisational objectives: CHAM facilities**

The main stated objective of all CHAM facilities is expressed in the CHAM advocacy strategy document (2009), which states that CHAM aims,

*“To contribute to the raising of health status of all Malawians by coordinating and supporting the provision of participatory, holistic, equitable and quality health care services provided by member health facilities”*

(CHAM advocacy strategy, 2009 page 9)

This broad objective has been disentangled to 5 specific objectives, of interest to this study is the specific objective on the delivery of health care services stating that CHAM facilities intends to ,

*“Promote quality of health care delivery in all CHAM facilities using participatory and gender based approach”* (CHAM Secretariat revised strategic plan 2008-2009 page 29)

This objective coincides with what respondents from various CHAM facilities stated, and these responses on the objective as reported by informants have been summarised as follows:

- Facilitate the provision of health care services to the communities in their catchment areas, especially the most vulnerable groups, such as pregnant women, children, orphans, people living with HIV/AIDS and people with disabilities, in line with their mission and purposes.

- Providing technical support to small health care facilities through referral programs
- Coordinating and developing health care services in partnership with other CHAM facilities in order to achieve quality health and patient care.

It was observed that responses from CHAM facility representatives varied from those referring to broad objectives of health systems strengthening, reduction of maternal and child mortality rates and fulfilling the compassionate mission of their proprietor to more specific ones such as the improvement of healthcare coverage, providing easy access to maternal and child healthcare services as well as improving the health of the people in their catchment area. Most of these objectives reflected those of the government and MoH in particular as stipulated in the Malawi National Health Plan (1999-2004) and Malawi health sector strategic plan -HSSP (2011-2016).

Furthermore, CHAM facilities expressed their objectives in terms of strengthening the relationship that has existed with the government for some time and achieving the long term goal of improving the performance of the health system. This they pointed out has been achieved by their involvement alongside the government in national initiatives aimed to improve the performance of the health system such as; decentralisation of healthcare delivery and management services, Sector Wide Approach (SWAp), Essential Health Package (EHP) and Service level agreements with government as well as other financiers of health care services such as donors and international NGOs. Similarly, the respondents argued that CHAM is operationalizing some major policies being implemented in the health sector such as;

- Millennium Development Goals (MDGs)
- Malawi Poverty Reduction Strategy (MPRS)
- Malawi National Health Plan (1999-2004)
- MoH Joint Program of Works (2004-2010)
- The National HIV and AIDS Policy Framework
- Emergency human resource program (EHRP)
- Malawi health sector strategic plan -HSSP (2011-2016)



CHAM representatives also stated that its objective was to help improve the health system by building the capacity of health workers through providing training to health care professionals. This was demonstrated through their commitment in training various cadres (nurses, clinical officers, medical officers, medical assistance, pharmacy assistants etc.) in colleges that are owned and managed by CHAM facility proprietors. A CHAM strategy document (2009) shows that CHAM health facilities employ 40% of graduates from CHAM training institutions: the remaining 60% are employed in other parts of the health sector (public health care facilities, private for profit providers and NGOs).

### **6.2.2.3 Organisational Development partners**

According to Oliveira Cruz (2008) responses by representatives of DP agencies varied from those referring to the broad goals of poverty reduction, economic development and provision of humanitarian aid to more specific ones such as the long term development of health systems and improvement of health outcomes. However, before adopting these responses as discussed in section 6.1.3, I first present the stated objectives of the four main development partners of the Malawi government, which are: DFID, USAID, GIZ and World Bank (Malawi government, 2010). The stated objectives of these four main DPs as documented in their strategic plans, operational plans and reports are presented next.

In their operational plan 2011- 2015, DFID Malawi have provided an overview of their vision to working with the government of Malawi, in implementing the Government of Malawi's new Growth and Development strategy (MDGS II:2011-2016) which DFID supported and contributed to its design. The overview of the vision states that,

*“We will give strong and sustained support to the government of Malawi to help Malawi's economy to recover and protect the poor. We commit ourselves to work in close partnership with the current government to improve the lives of Malawian citizens, especially girls and women. We will do this by building on programs that are delivering impressive results, including in health, HIV, justice and agriculture. We will scale up in areas where we can have a high impact and which complement other work, including water and sanitation in underserved areas and girls education. Our planned intervention will be mutually reinforcing: e.g. girls need toilets, closer water points and protection from abuse to attend school, and their education will slow population growth, deliver better health outcomes and higher earnings for them and*

*Malawi; improving sanitation will deliver better value for money in our health interventions.....”*

(DFID Malawi Operational 2011-2015 plan, 2012, page)

Similarly, in their strategic direction 2010-2015 documents, USAID Malawi has stated that, USAID/Malawi health sector program supports the increased availability of EHP services and increased utilization of EHP services. While USAID/ Malawi mission health statement is:

*“To promote, improve and protect the health and well-being of Malawians through investing in sustainable, strategic, high quality health initiatives and partnerships that support Malawi’s development goals and U.S foreign assistance priorities”*

USAID/Malawi strategic direction 2010-2015

In a similar manner, the Malawi Germany health program (2012) has stated that the broad aim of GIZ is to support the German government to achieve its international cooperation for sustainable development. Specific to the Malawi health sector, GIZ’s stated objectives are capacity development and supporting the creation of sustainable structures, with a focus on the following activities:

- Human resource development (the training of medical staff, organizational development within the human resource division of the ministry of health and operational research)
- Support to zonal health support offices provided by professional advisers placed from Germany on fixed term contracts
- Placement of German medical experts in local positions, chiefly in referral hospitals, who also contribute to pre- and in-service training of Malawian professionals.
- Promotion of public private partnership via service level agreements (SLA)
- Offering regional training programs for professionals involved in health sector reform, and in mainstreaming HIV and AIDS.

The stated objectives of the three bilateral DPs presented above are not very different from the World Bank. In their 2006 country assistance evaluation report, the bank stated that, the

overriding aim of the World Bank country assistance strategies (CASs) to Malawi was sustained poverty reduction by focusing on three broad objectives:

1. Macroeconomic stability and public sector reform – improved public financial management, reform of public enterprises, civil service reform and curtailment of the growing problem of corruption in public service
2. Broad-based, labour intensive growth, to be achieved through improvement in the environment for private sector development and agricultural productivity
3. Improvements in delivery of education and health services, in food security, and in social safety nets.

A synthesis of the broad objectives of the three bilateral DPs and the World Bank as presented here, suggest that, despite the differences in the wording of the stated objectives, these objectives are similar to those reported by Oliveira Cruz (2008).

### **6.3 Revealed and related conflicting objective functions**

This section will explore some revealed objective functions of government agencies, CHAM organisations and development partners. Revealed objective data were obtained from the behaviour of government agencies (principal), CHAM facilities (agent) and development partners in the SLA contractual relationship. If objective functions could easily be observed, an attempt to determine whether development partners, government agencies and CHAM facilities are acting according to their stated objective functions would be a straight forward exercise. Given that direct observation is not possible, alternative approaches are required. One such approach is indirect observation: observing behaviour and outcomes of economic decisions that can reveal objectives. The notion of revealed objective function is directly related to the revealed preference theory (Samuelson, 1938) which has been described as a method through which it is possible to discern objectives on the basis of observation of behaviour.

The issue of revealed objectives is important for at least two reasons. First, stakeholders in SLA, including development partners and country level policy makers would benefit from learning the current extent of CHAM facilities, donor agencies and government representatives efforts in pursuing their stated objectives. Secondly, the revealed objective function could potentially help to explain and address some of the challenges SLA is

encountering. The following subsections will outline some actions and behaviour that seem to be different from the stated objectives of CHAM, government agencies and development partners in relation to SLAs.

### 6.3.1 Is CHAM motivated towards SLA objectives?

While for long it has been taken for granted that CHAM facilities due to their religious obligations to the society will act in the interest of the population in their catchment area and in line with government objectives of providing health care to all citizens, there are instances in which CHAM facilities are believed to be pursuing religious, financial and political interests. Claims by some respondents noted that a number of SLA contracts were driven by the political interests of both the proprietors of CHAM facilities as well as the politicians representing the catchment area in which the facility is situated. GTZ (2010) has claimed that,

*“In some instances the due process of the SLA has been curtailed by pressure from politicians, MoH headquarters and proactive CHAM proprietors/administrators without giving adequate time to the DHO to think through the required process”*(GTZ, 2010)

To know whether CHAM is motivated towards SLA objectives or not, involves answering two basic questions. First, what are the objectives of the board of directors and proprietors of CHAM facilities? Second, do they really pursue the social objectives that are used to justify their status as recipients of government subsidy and tax exemption or do they focus on other objectives? Or is it the case that increased dependence on SLA revenue has blurred the distinction between their social objectives and objectives of surplus/ profit generation? Actions and behaviours of some CHAM facility stakeholders provide information that can shed light on these questions.

Like most faith based health care providers, CHAM facility's, priorities can be understood to be related to their Christian missionary objectives and their community rather than national policies. As part of the missionary objective, CHAM health facilities have developed, “*to proclaim the kingdom of God and heal*” (Luke 9:2) and a traditional CHAM facility location is a Christian missionary station which includes a church, health care facility and school. The health care facility help build the kingdom of God and demonstrate the visible signs of God's presence through their powers of healing and to look after the health of their own

missionaries, while the school helps contact with the community, especially where verbal communication is a challenge. In addition to the schools and health facilities, the mission stations provide compassionate services for people in need, out of pure Christian charity. However, in order to achieve these missionary objectives, the proprietors need resources (financial) to deliver the services.

Over the years funding from external financial donors directly to CHAM facilities has fallen considerably, forcing these facilities to look for alternative sources of funding. The findings of this research and Rookes (2010) indicates that church based organizations like CHAM facilities often seek good working relations with government agencies as a means of increasing the likelihood that they will be invited to participate in government policy and planning processes so that they can benefit from government funding in the process. This implies that CHAM facilities' objective in providing health care is at least partly to generate financial resources that could be used to promote their missionary activities, thus, health care provision is treated as a source of income to finance other missionary activities, which were previously funded by external donors.

CHAM facilities' objectives of advancing missionary activities can be construed from their attempts to maintain religious ethos, by preferring to recruit people from their own denomination, especially at senior posts. However, this presents the possibility that those better qualified for a job are excluded in favour of people with similar religious affiliation. Similarly, as a way of advancing their religious ethos, CHAM facilities especially those owned by the catholic church, do not work with government to promote reproductive health programmes aimed at reducing family size, by teaching that the mechanical methods of controlling birth are morally wrong and are not willing to provide family planning aid such as condoms. This is believed to have created tension between CHAM facilities' proprietors and government.

In relation to the allegations that some CHAM facilities' objective is to raise finances in order to promote their missionary agendas, some DHMT respondents alleged that some CHAM facilities valued the surpluses generated by SLA since they provide funds for investment, future philanthropic activities, perquisites, empire building and infrastructure expansion. For instance, there are anecdotes that some CHAM facilities still get support from various donors in the form of cash, material (drugs and medical supplies) and skilled labour

from overseas volunteers. The intentions of these donors are supposedly that these facilities will provide free or affordable health care to the needy. However, most CHAM facilities that benefit from such donations still, charge user fees and do not disclose the amount and kind of support they receive to government agencies who work closely with them. To illustrate this, some informants from CHAM facilities were specifically asked if their facility still received support from external donors. Most of these informants admitted this. However, when the informants were asked to provide details of the support, they were reluctant to provide the information. Similarly, when asked if they share the information on the donations they get with government, they argued that it was not necessary for government to know.

Considering that among the stated objectives of CHAM facilities was to work with, and support government in meeting the health needs of the population, it was generally rational to expect CHAM facilities to share information on all sources and amount of resources. The unwillingness to share information on their sources and amount of resources received, provided room to construe that the revealed objective of some CHAM facilities was to raise resources that could be used to promote various interests of CHAM actors, including advancing missionary agendas.

As an illustration of the foregoing, an administrator at one CHAM facility alleged that people who incur large bills after an admission at the facility are allowed to go home without making any payment, but are asked to come back and pay when they get the money. Considering that in such cases no user fees are paid and that some of these people have conditions that are not covered by SLAs, this suggests that the facility is using resources from external donors to meet the costs of such services. These instances may imply that some CHAM facilities are using their extra resources to provide compassionate services for people in need, out of pure Christian charity as well as to advance their missionary objective of recruiting followers through such compassionate acts. We can therefore construe that one of the main objectives of CHAM facilities is to recruit believers and they use resources from external donors and SLA to fund missionary work directly focused at attracting people to their churches.

A distinction noted among CHAM facilities was the influence of the proprietors (Roman Catholic Church, Anglican Church and the Presbyterian Church). In their letter, *living our faith*, which was read in Malawian churches on Sunday, March 8 1992, the Roman Catholic bishops made a polite but direct appeal for greater government accountability to the

Malawian people. The letter was a turning point from one party state to multiparty politics in the country. Mitchell (1992) has pointed out that the pastoral letter gave way to increase in prestige and influence of the catholic clergy in a religiously heterodox nation. In addition, the Roman Catholic Church is perceived to be powerful based on the number of their followers and health care facilities under CHAM. Because of these two factors, the Catholic Church has some influence in politics and national policies. The actions of these catholic proprietors have been interpreted by some government informant as the Church advancing political goals. For instance, DHMT informants have alleged that in some CHAM facilities the decision on the needs of the facility is not made by health care managers or medical personnel but by the religious leaders of the institution. They contended that this has led to prioritizing issues that do not directly benefit delivery of health care under SLA, but the political interests of the proprietors or of those that they support in government.

### **6.3.2 Is Government motivated towards SLA objectives?**

This subsection outlines some examples of where the behaviour of the government seemed to contradict the stated objective of improving health systems and coverage of health care services to ensure that all citizens have access to affordable health care as outlined in the Malawi National Health Plan (1999-2004) and the Malawi health sector strategic plan -HSSP (2011-2016). Government stated objectives are clear, but actions during implementation suggest that government is diverging from these, allowing construction of its revealed objective functions. The following practices by government are perceived by CHAM facilities as the revealed objectives of the government.

First, there was a perception among some CHAM officials that certain individuals in the government at technical or political level were more driven by political and financial benefits. Examples include negotiating for an SLA not based on need, but to meet political goals of those negotiating contracts. For instance, in some of the areas where there are overlaps of catchment areas between a functional public health care facility and a CHAM facility with an SLA, it was alleged that such areas are often home districts or political constituencies of prominent figures in government and political arenas respectively.

Second, local level government official's preferences and priorities seem to be different from those at the central level. For instance, the government has designated some CHAM facilities as district hospitals; the expectations are that these hospitals will be equipped to the same

standard as a government district hospital. However, these hospitals are under equipped, but as designated referral or district hospital, government expect them to treat all conditions that are treated at other government district hospitals. However, these facilities seem not properly prioritised by government, due to the preferences of government officials at the local level to allocate resources to public sector facilities over CHAM facilities. Given that these hospitals are in remote areas, where the majority of the population reside, this results in people not accessing quality health care services as outlined in government policy documents, a development which is not consistent with the government objective of ensuring that better quality health care is provided in all health care facilities.

Third, the lack of a budget line for SLA monitoring and evaluation processes at the Ministry of Health headquarters raises suspicion that the SLA policy may not be a priority area. CHAM and DHMT informants alleged that despite the clear capacity constraints which limit the extent to which MoH can implement and monitor SLAs, there has been less effort by the government to monitor and evaluate SLAs. However, without monitoring and evaluating SLA activities, it is less likely for government to ensure the quality of services being provided. In this regard the objective of providing quality services in the absence of monitoring and evaluation does not make sense, as the government cannot tell if the service being provided is meeting the quality criteria or not.

Fourth, despite the government having clear stated objectives on the delivery of health care and expected outcomes, these objectives in some cases are in conflict with those of individuals at various levels of government. For instance, the government objective is stated to be to increase coverage and access through involving the private sector in health care provision, but government officials at the district level seem not to prioritise SLA payment but focus more on other budget items, even those that may not have direct impact on health indicators. This is illustrated by delayed and non-payment of SLA bills in favour of allowances, but also on sentiments expressed by government officials at the local level as explained earlier. However, this is not consistent with government policy of working with private health care providers to enhance health care delivery, but seems to imply that the priority of those at the local level is to grow the public sector by pursuing activities and agendas that favour public provision as illustrated by a DHMT informant who argued that:



*“The government should just build their own hospitals and let CHAM continue with their business” (DHMT informant)*

Based on the observation in the preceding paragraph and the statement from the DHMT informant, we can deduce two points. First, government officials at the implementation level believe that to share health care provision with CHAM facilities undermines the public sector historic role and pledge to provide health care services to their population. Second, some government officials perceive that finances allocated to CHAM either directly or indirectly by the state or development partners reduce financial resources available to support public sector provision of health services. This implies an assumption that government objective is to grow public sector activity rather than to achieve population health objectives.

### **6.3.3 Are development partners motivated?**

In this section, findings from Oliveira Cruz (2008), policy documents on the Malawi health sector and reports from various stakeholders are used to illustrate behaviours of DPs in relation to revealed motives in providing aid.

First, government officials struggle to obtain expenditure information from DP representatives within the country. Oliveira Cruz (2008) has stated that, a number of DPs still persisted in not declaring their budgets or doing so in an incomplete way. Oliveira Cruz (2008) further pointed out that during the preparation of the Ugandan NHA in 2004, obtaining expenditure data by donors was one of the most challenging aspects of the exercise. Similarly, when the Malawi Ministry of health prepared the first and second NHA (2004 and 2006), the government encountered challenges in obtaining health expenditure data from donor organizations. In both countries the results had been that donor expenditure data were patchy. For instance, the Malawi NHA report that was published in 2001 points out that,

*“The most difficult funding estimate to obtain was those of donors and NGOs” (NHA, 2001)*

Similarly, five years after the first NHA report, the second report in 2007 also highlighted the limitations of the exercise due to some donors withholding data on their expenditure on health. The report points out that,

*“in order to capture donor contributions for health, a special donor survey targeting all 19 donors in health was undertaken..... however, the response rate was poor – only 40% responded despite several follow- ups” (NHA,2007)*

Where donor information on aid disbursement is poor, government planning and budgeting is based on partial and inaccurate information. The reluctance by some donors to provide information on actual contribution to the health sector therefore raises questions of their commitment to the stated objectives of supporting the Malawi government to strengthen the health system.

Second, the unpredictability of aid flow, in terms of amount to be released and timing casts doubt on the seriousness of some donor agencies in meeting the stated objectives. While the donor may provide the overall intended amount of aid to the country, uncertainties in amounts and timing of donor contributions as well as channels, disrupt planning and disbursement of budget allocations. In regard to the unpredictability of donor funding in Malawi, OECD (2011) has noted that,

*“ In 2007-2008, donor disbursement was 10% more than pledged due to the increase by the Global Fund and World Bank, in 2009- 2010, the disbursement by pooled donors was below the pledged amount by 39%, while that from discrete donors were 72% below the pledge” (OECD,2011)*

In addition, the African development bank (AFDB) (2009) has pointed out that,

*“Nevertheless, government officials consider that the global fund has very bureaucratic and cumbersome procedures and requirements for disbursements. One example is Malawi’s round two malaria grant which was put together in 2002 but was only signed in 2005, and whose first disbursement was in 2006” (AFDB, 2009, page, 16).*

On DPs channelling aid to Malawi through NGOs, the Malawi NHA (2007) has pointed out that,

*“Donors channel large amounts of their funds through NGOs without the knowledge of the Ministry of Health” (NHA, 2007).*

The unpredictability as well as the channelling of aid through NGOs as outlined here may be due to a number of reasons including DP agency internal administrative problems and change of priority by the DP country. However, this raises questions about the implications of such actions on health programs as planned by the Malawi government.

Third, there is generally lack of alignment of some donor funded projects towards Malawi health sector priorities and policies as well as the fragmentation of donor projects which adds to the already weak functioning of the system. The lack of alignment by DPs mostly involves encouraging activities that undermine Malawi's institutions, such as developing parallel systems without thought of transition mechanisms or long-term capacity development. Due to DPs' disregard of the country's systems and policies, the capacity and legitimacy of the government have been undermined as the key functions (planning and financing) have become donor driven. For instance, OECD (2011) has pointed out that,

*“In Malawi, there are more than 20 donors who are funding more than 100 projects in the health sector outside the SWAp” (OECD, 2011 page 3).*

Similarly, OECD (2011) has noted that,

*“Even in the context of well- established SWAps, such as in Cambodia and Malawi.....,...which donors are expected to use them, there continues to be modest and sometimes inconsistent use of country systems” ”( OECD,2011 page 3).*

In addition, Tew (2008) has documented that,

*“There appears to be a large amount of project-based aid to Malawi for which GoM has insufficient information to know where this aid is being disbursed and for what purpose. This makes it unnecessarily difficult to align the development efforts of the GoM with aid interventions funded by donors” (Tew, 2008, page 6).*

Furthermore, Tew (2008) has cited an example whereby,

*“The Director of Malawi's Health SWAp (Sector-Wide Approach) expressed concern at her lack of knowledge with regard to some donor-funded aid projects in the health sector.*

The author contends that,

*“these projects could be duplicating the efforts of the Malawi Ministry of Health(MoH), or else gaps between donors’ plans and those of MoH could mean some groups missing aid on some forms of health provision”*( Tew, 2008, page 6)

On DPs lack of alignment, MoH (2010) has reported that, the health sector has the highest number of development partners in the country. However, the report points out that, while most of these development partners are working together through the SWAp, others are still inclined to follow the parallel project approach. Similar views have been echoed by AFDB (2009),

*“Donor proliferation seems to be particularly pronounced in the health sector in Malawi, where many organizations are involved ... The VHF<sup>6</sup>s in Malawi dominate the financing of the health sector and narrowly target the specific priority diseases. Benefits have been well noted. Yet, not addressing the entire health system creates pressure points and weaknesses across the sector”*

(AFDB, 2009, page, 17)

MoH (2010) further point out that, even DPs that provide funding through the SWAp basket also fund individual projects. AFDB, (2009)

*“While the health sector SWAp calls for a common framework for the health sector planning and monitoring and evaluation, some donors in Malawi (i.e., which are not signatories of the MOU) still keep separate planning and reporting system”*

(AFDB, 2009, page, 3)

In addition, MoH (2010) has noted that, DPs that do not participate in the SWAp cite the need to earmark funds to specific projects, as a way to derive results and demonstrate attribution as well as visibility of their aid, regardless of the impact on the people or Malawi as a country. AFDB (2009) has pointed out that,

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<sup>6</sup> Vertical Health Funds

*“Multiple aid channels impose additional strain on already weak implementation capacities in low income countries, including Malawi and obviously off budget aid presents a challenge in terms of transaction costs and human capacity”*

(AFDB, 2009, page, 3)

The objectives and procedures of these parallel projects often favour and promote short term results over long term impact, contradicting the objective of helping the economic development which may require investment in policy interventions that have long term impact.

Fourth, ownership problems occur when DPs impose an intervention on recipient governments, without the recipient government having a say in the process of identifying and planning. Ownership means the recipient country has not merely agreed to an externally supported intervention, but is genuinely committed to it. Van de Walle and Johnston (1996) have pointed out that, “recipient governments can be said to own an aid activity when they believe that it empowers them and serves their interest”; while Unsworth (2001) maintains that local ownership must mean local leadership. In Malawi, the health sector SWAp on paper is owned by the government, but actions and activities suggest that it is dominated and controlled by DPs. Bowie and Mwase (2011) have pointed out that,

*“Donors may be prepared to relinquish individual health projects and contribute to a basket funding through a SWAp so long as the health sector plans for which the basket funding are used address health priorities in an efficient and effective way”*

(Bowie and Mwase, 2011)

However, instead of empowering and relinquishing individual projects to local people, as expressed by Bowie and Mwase (2011), DPs still control the operations of the SWAp remotely using various mechanisms, including the use of technical experts. MoH (2007) has pointed out that,

*“Technical assistance is usually effective, but is failing to build capacity, has serious detrimental effects and is expensive” (MoH 2007, page 157)*

Similarly, Witty (2011) has pointed out that,

*“One donor representative noted that while the process of strategy setting involved discussions with Malawian government and while they played ‘lip service’ to country ownership, in reality the government of Malawi’s priorities would be of secondary*

*importance to the consideration of their stakeholders in their HQ (key interviewee discussion). Even in the case of the EU and the World Bank, where the government of Malawi has the formal sign off power on planning documents, interviewee noted that this did not in reality transfer power” (Witty, 2011,page 33)*

The results of Witty (2011) are similar to World Bank (2006) which noted that,

*“While the joint staff assessment was highly positive about the participatory process that supported the PRSP, and the degree of government ownership of the document, there is a widespread view and perception in Malawi that the PRSP carries an excessive degree of bank and fund authorship” (Witty, 2011,page 33)*

Some of the actions of DPs in Malawi as illustrated here are not consistent with their stated objective of sustainable development and capacity development. The actions however imply that DPs in general are interested in visibility, attribution, commercial and political influence. These interests may be construed as the revealed objectives of the DPs.

Table 6.1 summarises the probable incentives and disincentives of government, DPs and CHAM constructed and based on the analysis and interpretation of data discussed in this chapter.

**Table 6.1 Summary of probable incentives and disincentives to implement SLA**

	<b>Incentives to implement SLAs</b>	<b>Disincentive to implement SLAs</b>
Government Ministry of Health	<ul style="list-style-type: none"> <li>- Enhancing its legitimacy and authority</li> <li>- Increasing coordination and ownership</li> <li>- Bringing the contracted private sector providers into the framework of government policy</li> <li>- Circumventing the rigidities of public sector administrative framework.</li> </ul>	<ul style="list-style-type: none"> <li>- Perceived loss of sovereignty/authority/role</li> <li>- Reluctance to associate with private health sector providers</li> <li>- Loss of opportunities for patronage and extracting resources by officials</li> <li>- Loss of resources which could be used to grow public sector service delivery</li> </ul>
CHAM Facilities	<ul style="list-style-type: none"> <li>- Provide health care services in line with their mission and purposes</li> <li>- Access longer-term and more predictable funding as compared to the user fees that they charge</li> <li>- Be part of a permanent</li> </ul>	<ul style="list-style-type: none"> <li>- Financial security concerns due to potential non commitment of government</li> <li>- Erosion of independence as a government contractor</li> <li>- Capacity weakness in government which impacts</li> </ul>

	contract with government, donors and user - Enter into new markets and scale up operations	on its operations - Preference for direct contractual arrangement with major donors
Development Partners	- Help promote health care provision and reduce the disease burden - Promote and maintain their visibility as well as attribution of their contribution - Use SLA to pursue commercial and institutional interests. - Promote foreign policies	- Increased transaction costs for donor agencies in new approaches to aid as dictated by the Paris declaration - Emphasis on recipient country's ownership of the intervention funded by donor agencies - Harmonisation and alignment procedures and policies, which may reduce their visibility and attribution

In summary, the stated and revealed objectives of the government, DPs and CHAM are key factors in explaining and understanding the operationalization of SLAs and the implications for access, equity, quality and efficiency of healthcare services offered through SLA.

## 6.4 Conclusion

The findings in this chapter demonstrate that the objective functions of CHAM facilities, government agencies and development partners contained a range of arguments. The objectives of the government, DPs and CHAM are key factors in explaining and understanding access, equity, quality and efficiency of healthcare services offered through SLA.

In an effort to further understand the objective functions of CHAM, government and DP agencies in relation to SLAs, the behaviours of both organizations were contrasted to the claims made in their stated objectives as discussed in the previous section. The results from the contrasting exercise indicate that some revealed objective functions within CHAM, government and DP agencies as well as between government, CHAM and donor organisations are contradictory. The contradictions between stated and revealed objectives partly explain the challenges faced in the implementation of SLA.

The problems of conflicting stated and revealed objective functions as explained in this chapter are exacerbated by the presence of multiple agency relationships within CHAM, government and development partners. The next chapter will explore the presence of multiple agency relationships in government agencies, DP organisations and CHAM facilities; various mechanisms that these actors use to reshape each others' incentives ; and how the reshaping of incentives affect the effectiveness of SLA contracts.



## **Chapter 7: Shaping of incentives within the multiple agency relations in SLA contracts**

### **7.0 Introduction**

In this chapter, I first review the multiple agency relationships that exist in the SLA mechanism and try to identify the various stakeholders present in key organisations (government, CHAM and development partners) involved in SLA. Secondly, given the multiplicity of agency relationships, I examine the various mechanisms through which these stakeholders shape the elements of the incentive environment for each other and how this may impact on the operation of SLAs. Examples of incentive shaping are presented and analysed. Thirdly, in view of the shaping of incentives through the interactions of government, CHAM and development partners, I review the possible winner, “who is managing who” and who is successful in using their influence to reshape the incentives of the other.

Contractual relationships in which the principal wishes to affect the actions of the agent by means of incentives are abundant. The original formulation of the principal agent relationship (Arrow, 1963) in health care service delivery focused on the physician as the agent of the patient (the principal). However, health care delivery in Malawi like most countries is characterised by multiple principals and multiple agency relationships. For instance, within the Ministry of Health, such kinds of arrangements are present between government agencies at the central level as principals and those at the local level as agents. Outside the public sector, MoH agencies can be seen as principals to CHAM facilities, while development partners can be seen as principals to the central government, MoH agencies and CHAM facilities that receive direct support from DPs.

The evidence for this chapter is a combination of data assembled from the main data sources used for this research. Similar to the sources used in the previous chapters, here I have combined informant responses and quotations from published literature, government and other stakeholders’ reports.

## 7.1 Multiple agency relationships

In this section a general overview of multiple agency relations, which characterises SLAs, is presented and analysed.

The provision of health care services through SLA in Malawi involves three key actors making decisions relevant to the outcomes. These actors are the government of Malawi (central government, DHO and Zone officer serving as government official responsible at the local level) bilateral/multilateral development partners under the health sector SWAp, and CHAM at the secretariat and CHAM facility level.

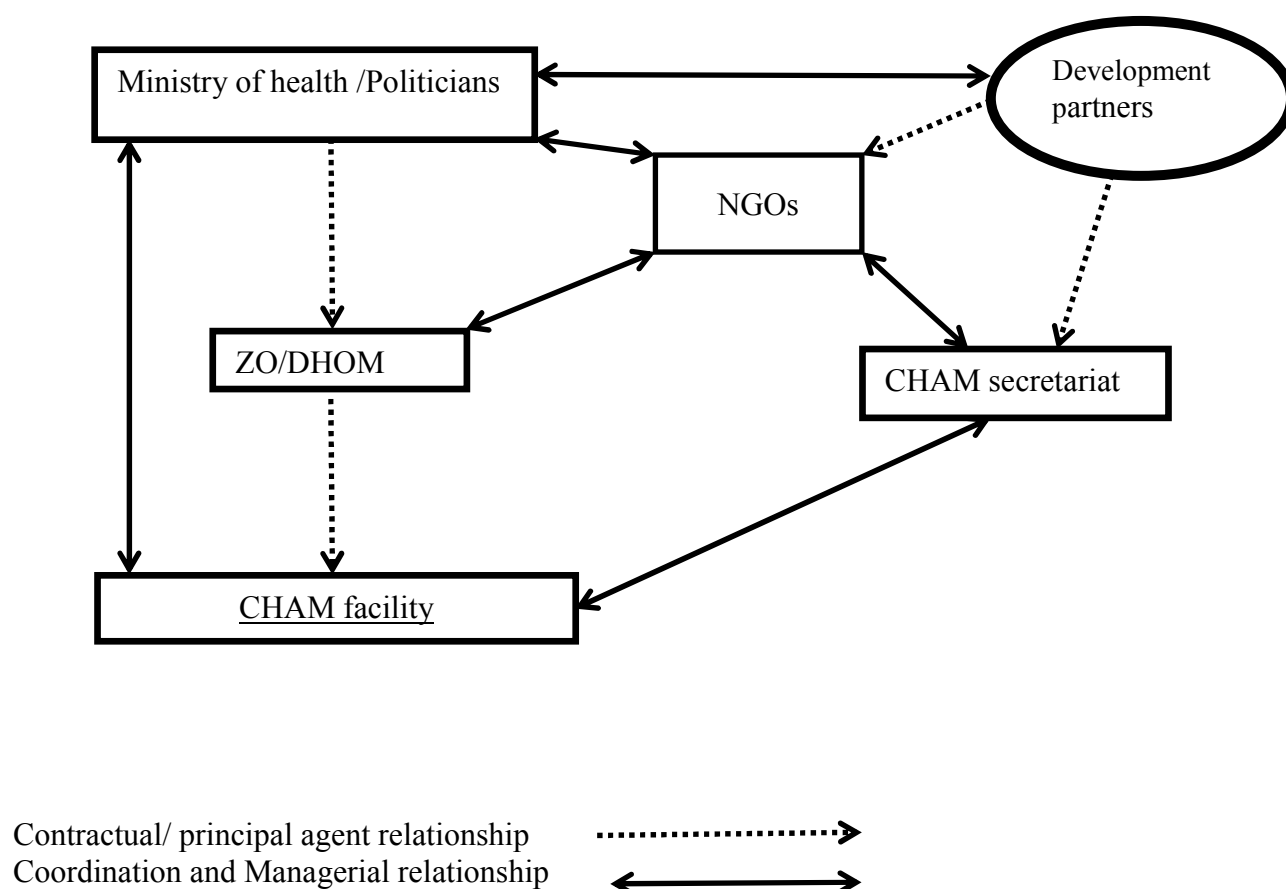
Relationships among these various players as outlined above are multifaceted, characterised simultaneously by two factors. First, different players have different layers of authority within them. For instance, the government or financing agency has officials at the central level who delegate authority to officials at the local level. Likewise, CHAM has principal agent relationships involving CHAM secretariat, proprietor, and facility managers, while in development partner organisations, principal agent relationships start from tax payers in donor countries, to politicians and the implementing agencies.

The implications of these multiple agency relationships relate to how negotiations are conducted through government bureaucratic chains in consultation with CHAM proprietors and involvement of development partners who contribute to the SWAp basket, the main funding source of SLAs. The picture of these actors tacitly accepting orders, executing but not making policy choices, and motivated only to forward the SLA appears unrealistic. It is therefore necessary to look closely at the individual actors within government, donor and CHAM organizations and how these individual actors influence the relationship of the various organisations under discussion here. For instance, what are the rewards and penalties facing an actor located in the hierarchy and what sorts of behaviour would describe their efforts to maximize utility.

Figure 7.1 is a configuration of a multiple agent relationship, in which MoH, CHAM and development partners delegate tasks to each other as principals and agents, and how the agent further delegates the task or some part of it to a subordinate actor. The longer the chain of delegation, the higher the potential of efficiency loss at each stage in the chain, and the incentives of those further away in the chain are further removed from those of the principal. Turner and Kotzian (2001) have argued that non intended expenditures (transaction costs)

should increase the higher the number of agency relationships related to the budget producing process. This suggests that this effect is aggravated the higher the number of agency relationships that are not monitored by appropriate control mechanisms, and the lower the appropriateness of the controlling mechanisms. As illustrated in figure 7.1, Ministry of Health officials delegate management of SLA to DHOs, while the DHOs delegate the roles to CHAM facilities.

**Figure 7.1: Configuration of principals/ agents and relationships in SLAs**



Similarly, development partners act as principal to the central government through budget support or similar funding mechanisms. Development partners can also act as principal to CHAM secretariat when they channel aid through CHAM.

Development partner organisations here represent the agents of the donor organisation such as international and national NGOs who interact with government and CHAM secretariat or directly with CHAM facilities and district health offices. While most NGOs are not directly involved in SLA, key NGOs such as UNICEF are linked to CHAM facilities through the

government and directly when need arise. For instance, UNICEF and USAID have in the recent past procured and distributed drugs and medical supplies to all government and health facilities under CHAM. It is likely that some of the drugs and medical supplies allocated to CHAM facilities will be used for SLA. The next subsections will illustrate the presence of multiple agency relations within CHAM, Ministry of Health and DP organisations, highlighting the various stakeholders involved in these organisations.

### **7.1.1 Multiple agency relations within CHAM**

There is a memorandum of understanding between the government (Ministry of Health) and the Christian Health Association of Malawi (CHAM) which was signed on 9<sup>th</sup> December, 2002. Article 2 of the MOU outlines the various stakeholders involved in the relationship between government and CHAM;

*“CHAM shall have a governing body to be known as Christian Health Association of Malawi General Assembly (here after called the “General assembly”)”*

*(MoH and CHAM MOU, 2002)*

The MOU further states that the membership of the general assembly is comprised of the Malawi council of churches, the Episcopal Conference of Malawi and associated members as well as the Secretary to the Treasury and the Secretary for Health or their representative shall represent the government in general assembly meetings. The general assembly’s primary functions are –

1. To advise on policies related to health services provision by CHAM facilities, within the context of national health priorities
2. To monitor health intervention programs for the provision and expansion of services in CHAM facilities
3. To oversee the administration of finances ( granted, generated, allocated and borrowed) for the purposes of the provision , improvement, rehabilitation and expansion of health services by CHAM facilities

In addition to the general assembly, each CHAM hospital and health centre has a governing body known as a Health Board of Governors and Health Centre Advisory Committee respectively, for the purpose of overseeing the management of the facility. Members of the board /committee include representatives from the District Health Office, District Assembly,

and member of the community from the facility catchment area, CHAM secretariat and the proprietors of the facility.

Furthermore, CHAM facilities have a management team, usually comprised of the administrator, doctor and matron, who manage the day to day operations of the facility. The organisational structure of CHAM facilities has a top down hierarchy, where the administrator is the principal with the other members of the management team as his agents; each of these management members have their own lower level agents in the section that they are assigned.

In addition to this, it is also worth noting that CHAM facilities are owned by churches which established them to pursue religious ethos. This implies that, at church level there are also committees responsible for the affairs of the facility. Importantly, the church committee is not only influenced by the local leadership, but religious donors who support the activities of these churches, including the provision of health care through the facilities.

The discussion above implies that CHAM's policy is a result of complex negotiations between various stakeholders including constituent church proprietors, each with their own denominational ideology and priorities, and represented by actors who may understand little of the dynamics and dilemmas of the health system. For instance, there is a lack of expert knowledge by bishops on the quality of health care provided in their health facilities.

### **7.1.2 Multiple agency relations within government**

The issue of multiple agency relations at central government level is broadly conceptualized based on citizens who act as principals, and elect politicians as their agent. The politicians in turn as principals appoint bureaucrats (civil servants) to implement various programs. Similarly, the bureaucrats at the central level acting as principals appoint local level government officials as their agent.

In the SLA scenario, Ministry of Health officials are principals, while health care professionals at the zone and district level are their agents. In public settings like these, considerable slippage of information occurs along the chain of command from voters to elected officials and from appointed contractor to beneficiaries. These different principals

might have different information and perspectives concerning the outcome of various tasks carried out by the agents, as illustrated by one MoH informant:

*“government wants to work with the private sector in order to achieve its goal of providing affordable health care to all Malawians”*(MoH informant)

On the contrary a DHMT informant pointed out that,

*“The government should just build their own hospitals and let CHAM continue with their business”* (DHMT informant).

These conflicting statements from informants as presented here suggests that, despite both informants being from government, they may have different information and perception of SLA, and this may have some implications for the delivery of SLA services.

The problem of information and perceptions is more prevalent in government agencies where conflicts between and within government departments with different interests give rise to significant disjuncture between government agencies and the localities they operate in. Some stakeholders in the multiple agency relationship are more powerful than others, for example, senior government officials and political actors enthusiastically support the contractual process, dominate the agenda and then pull out from or override the initiative when it suits their own goals. For instance, both CHAM and government informants as well as reviewed documents (GTZ, 2009; GIZ, 2011; CHAM, 2009), have shown that senior government officials and politicians had influenced the signing of SLA contracts in some areas, but failed to enforce the payment of SLA fees and renewal of contracts, nonetheless expected CHAM facilities to keep providing health care services. This type of behaviour take place regardless of its problematic implications for other stakeholders and the intended beneficiaries'. Because of the agency problems described here, different forms of resistance to working with each other develop, limiting the impact of the SLA policy.

### **7.1.3 Multiple agency relation in development partner organisations**

DP organizations have been treated as if they were individuals or bundles of individuals, all responding to similar incentives in the same way. However, DP organizations have multiple

principal relations, which start from taxpayers who contribute to the budget, politicians who vote to approve the budget, recipient agencies, contractors, politicians and other principals in the recipient country.

At the country level, DP agencies interact with the Malawi government and its agencies based on a principal agent model. In recent years, apart from the budget support that DPs provide to the government, most DPs also contribute to the SWAp basket. CHAM and MoH informants argued that the introduction of SWAp has increased resources available in the health sector and that some of these resources are used for SLA. In addition, reports by bilateral donor agencies such as GTZ/GIZ, DFID and NORAD (GTZ, 2009; GIZ, 2011; Pearson, 2010; NORAD, 2009) attest to the involvement of donor organizations in SLAs.

There is also some evidence that, some DP agencies have not directly worked with government as illustrated here. However, these DP agencies have funded both international and local NGOs which have worked with the government in various capacities. For instance, NHA (2007) reported that some DP agencies have contracted nongovernmental organizations (NGOs) to disperse aid. Specifically, the NHA (2007) has stated that,

*“Donors channel large amounts of their funds through NGOs without the knowledge of the Ministry of Health” (NHA, 2007).*

The foregoing illustrates that, DP agencies have a more complex array of links with stakeholders including central government agencies, local government authorities, CHAM secretariat, CHAM facilities and NGOs. This has implications for their roles as funders and as policy influencers as well as their relationship with each of these stakeholders. In addition to the apparent principal agency relation with various stakeholders as illustrated above, DPs also work with other bilateral or multilateral organisations, which may also influence their behaviour and actions. For instance, when the United Kingdom government, suspended financial support to the Malawi government in 2011, other bilateral and multilateral DPs, followed by withdrawing budget support as well as other development assistance to Malawi. The presence of multiple agencies in DP organizations as presented here is likely to pose a number of challenges in the delivery of health care services under SLA, as not all stakeholders may act in the interest of the DP organization.

## **7.2 Government, CHAM and DPs inter-relationships**

Following from the discussion on multiple agency relationships above, it is possible to discern a range of challenges facing government, CHAM and DPs while working in environments characterised by multiple agency relationships, particularly those factors that might ameliorate or hinder effective provision of health care under SLA contracts. However, what remains unclear is the extent to which these factors or challenges are prevalent across SLA contracts, felt by those working at a policy and implementation level, or contingent on different model or types of SLA agreement e.g. comprehensive or maternal and child SLA. In the next subsection, I will address these questions by outlining possible ways that CHAM, government and DPs enable and constrain each other and examining the implications for the delivery of health care under SLA.

While we recognize that there are a number of enablers in government, CHAM and DP inter-relationship including; government providing salary to all CHAM employees; CHAM willing to implement public health policies and DPs providing funding and technical expertise in the health sector. The discussion here will focus on the constraints in the inter-relationship, as these are thought to be negatively affecting the implementation of SLA.

### **7.2.1 CHAM facilities constraining government**

There are indications from the results of this study that the actions of CHAM, some at secretariat and others at facility level, constrain government in pursuing its objectives. Some of the actions by CHAM which are thought to constrain the government are discussed and analysed next.

#### ***7.2.1.1 Transparency***

There is a general lack of transparency by most CHAM facilities regarding finances and other resources that the facilities obtain from various sources. The research found that there is wide belief amongst government officials that CHAM facilities continue to receive substantial financial support from their local and international religious donors including the founding churches in high income countries. While some CHAM informants acknowledged that they continue to receive financial support from these sources, they however claimed that, it is usually less than perceived by government officials.



CHAM informants expressed concern that government officials were interested to know the source and amount of external financial support CHAM facilities receive. On the contrary, government alleged that they find it difficult to judge the appropriate support to CHAM facilities when the amount of external contribution is not known. The non-disclosure of financial and other external support that CHAM facilities receive from various sources, has prompted some government officials to speculate that CHAM facilities have enough resources to provide health care services and that they should not receive financial support from government through SLAs. On the contrary, CHAM facilities insist that they have limited resources to provide health care services and that the support of government through mechanisms like SLA will help them to deliver health care services. Even though we were not able to establish the reasons behind CHAM's reluctance to disclose information on financial and other external support, GTZ (2009) has suggested that CHAM facilities are not willing to disclose this kind of information in order to have extra resources and maintain their autonomy and provide other services not covered by SLA, as one way of advancing their religious ethos. The seeming information asymmetry between CHAM and government as portrayed here, partly unveils the reasons for the growing mistrust between CHAM facilities and government officials in their SLA contractual relationship.

#### ***7.2.1.2 Opportunistic behaviour***

It is claimed that some CHAM facilities have behaved opportunistically by first requesting payment for patients whose existence the government has failed to verify and second by overcharging the government on transport expenses. Even, though government officials were not able to provide clear evidence of these practices, they have alleged that most CHAM facilities are involved in them. Based on these observations, some government officials are reluctant to engage with CHAM facilities, or work with them cautiously as they suspect them to be using SLAs as an income generating activity, to finance missionary related activities which have nothing to do with health care provision.

#### ***7.2.1.3 Refusal and reluctance to implement some health care intervention***

Some CHAM facilities due to their religious beliefs have refused or shown reluctance to join the government in implementing national reproductive health interventions, for instance by refusing to distribute family planning products like condoms and other contraceptives. CHAM facilities especially those owned by the Catholic Church, do not work with government to promote reproductive health programs aimed at reducing family size, by

teaching that the mechanical methods of controlling birth are morally wrong. This behaviour represents a conflict between public health and religious/moral imperatives and shows that religious/moral imperatives prevail, and this is believed to have created tension between some CHAM facilities and government.

The reluctance to disclose the type and quantity of resources from their sponsors, the alleged opportunistic behaviours perpetrated and refusal of some CHAM facilities to provide family planning products is thought to have contributed to some government official resentment in relation to working with CHAM facilities, thereby constraining the government objective of working with CHAM facilities to improve access to quality health care services.

### **7.2.2 Government constraining CHAM**

Similar to CHAM facilities, government actions, some at the central level and others at the local level, constrain the effort of CHAM facilities to effectively provide health services. Some of the actions by government agencies which are thought to constrain CHAM are discussed and analysed next.

#### **7.2.2.1 Political and economic stability**

Government constrains CHAM facilities by not guaranteeing political and economic stability or a legal system that would ensure contractual rights. Most CHAM facilities need more binding and more specific agreements on policy documents. Kadzamira et al, (2004) has pointed out that,

*“The period of political instability immediately before and after the elections had implications for the relationship between government and non-state providers, in that government ministers and ministries were unsure of their future positions, and the non state providers were unsure of the nature of future relationships with government. Practical implications of this uncertainty included delays in drafting and signing documents and formalizing relationships between government and non-state providers”* (Kadzamira et al., 2004, page 2).

Furthermore, Kadzamira et al, (2004) claim that the elections in 2004 highlighted the political salience of the relationship between government and CHAM, as the election campaign drew

attention to the tension between the government desire to achieve the provision of health care for those in need, and its own incapacity to do so. Within CHAM, there was a feeling of pressure to deliver care before the service agreements had been signed. Although these ad hoc relationships succeed due to mutual dependency between CHAM and MoH, the consequences are that there have been duplications and non payment.

In regard to instability, Kadzamira et al, (2004) have argued that,

*“the relationship between government and CHAM is characterized by an element of mistrust, which arises out of a history of instability in funding arrangements between the two parties, with anecdotal evidence from CHAM suggesting that previous experience has shown that the government is sometimes unable to deliver the financial resources which it had allocated to CHAM”* (Kadzamira et al., 2004, page 3).

The forgoing suggests that, political and economic instability constrain the effectiveness of the working relationship between government and CHAM facilities in providing health care services through various mechanisms, including SLAs.

#### **7.2.2.2 Non involvement of CHAM facilities**

Second, there are indications of non involvement of CHAM facilities in health planning activities at the district level. District health officials’ actions of not involving CHAM organizations in DIP and other health planning activities is not in line with the MoH objective of working with private providers to improve health outcomes. The DIP (2005) document has pointed out that,

*“CHAM institutions, development partners and NGOs are expected to contribute to this process per the guidelines provided under the planning and budgeting process”*  
(DIP, 2005, page, 19)

However, there is little participation of CHAM institutions in DIP activities in most districts. GTZ (2009) has stated that,

*“Another related challenge is the non participation of CHAM facilities in the DIP process. The DHOs report that CHAM managers do not attend nor share their*

*plans with them despite invitations sent. On the other hand, the CHAM managers report that they are never invited to attend the DIP planning by the DHOs nor do they get copies of the DIPs. One possible reason behind these mutual accusations between these two contracting parties could be conflict of interest which is largely structural in nature” (GTZ, 2009, page, 11)*

Similarly, CHAM (2009) has pointed out that,

*“Although CHAM is an important stakeholder in the delivery of health services, their involvement in the policy and decision making processes and forums at district level is minimal. At district level CHAM is not effectively represented in the District Executive Committee, the District Health Management Committee and it has limited involvement in the formulation and implementation of District Implementation Plans (DIPs)”*

(CHAM, 2009, page, 14)

By not involving CHAM facility managers in the DIP process, the government misses the opportunity to establish realistic estimates and transparency in identifying what resources they have available, resource requirements and health services outputs. In addition, participation of CHAM facility managers in DIPs could be used as a measure of commitment to SLAs in their monitoring and evaluation (GTZ, 2009). The isolation of some CHAM facilities in some districts from DIP due to the reluctance of government officials, as illustrated here, seems to constrain CHAM facilities activities.

### **7.2.2.3 Incomplete decentralisation**

The seemingly incomplete decentralization process in the public health sector impacts on the implementation of SLAs in the sense that, while local level responsibility exists, the people at the local level operate in a strong environment of centralization which complicates the management of the contractual relationship (Boulenger et al., 2009). This suggests that complete institutionalization and operationalization of the decentralization process might support improving and optimizing the implementation of SLA contracts between CHAM facilities and government agencies.

CHAM informants alleged that government representatives at the local level have no decision power in the negotiation. Given that decision making powers between CHAM facility

managers and government agencies differ, there is unbalanced negotiation power in the contractual relationship between government and CHAM facilities. The informants further claimed that, government representatives would often go back to zone officers or other government officials at the Ministry of Health to discuss seemingly straight forward issues pertaining to SLA contracts. The informants further claimed that this power imbalance slowed down SLA contract renewals and price revision negotiations. Informants from government agencies admitted the challenge of prolonged decision making processes, but pointed out that this was the way decisions are made in the government machinery.

In addition, informants alleged that authority boundaries were also a key challenge in that the authority boundaries of the government agencies involved in SLA were not clear, this was thought to be a disadvantage to CHAM facilities. For instance, it was noted that Zone officers and DHO authority and boundaries were not clear when dealing with SLA matters. Informants alleged that, despite the DHO being the officer in charge of health care provision activities and responsible to negotiate SLA contracts with CHAM facilities, the DHO has no authority to negotiate price changes. In addition, there are overlapping and ambiguous functions between Zone officers and DHOs, leading to some functions not being performed as the two public agents pass on the responsibility to each other ending up confusing CHAM stakeholders. A DHMT informant pointed out that,

*“Well functioning SLA should have well defined aims and objectives, clear allocation of roles and responsibility as well as incorporate some uncertainty”.*

(DHMT informant)

#### **7.2.2.4 Inflexibility and bureaucracy**

CHAM facilities are constrained by the inflexibility of the bureaucratic systems of government through administrative systems such as completing forms, submitting contract documents and writing reports which are believed to consume more time. The introduction of bureaucracy in the day to day business of CHAM facilities is alleged to stifle efficiency benefits and increase transaction costs. For instance, CHAM informants pointed out that the bureaucratic process of public procurement itself through completing numerous documents and attending endless meetings demands a lot of resources (financial and human), undermining the efficiency of some CHAM facilities.

Related to bureaucracy are organisational differences. Organisational differences here refer to variations in organisational set ups in both CHAM and government. These differences

manifested themselves in a number of different ways such as authority structure and boundaries, different working conditions and expectations; inter agency rivalries, different working methods and roles. CHAM facilities are organizations that are privately owned and not part of the government, their proprietors are churches. On the other hand public sector agencies like Ministry of Health, Zone offices and district health offices are established by statute or similar regulation passed by government, that is, they are owned and operated by government. Therefore, health care managers cannot change them according to the changing conditions.

#### ***7.2.2.5 Loss of autonomy***

There are concerns about the loss of autonomy by most facilities due to involvement in SLA contracts. Despite that CHAM facilities benefit from government through greater funding and opportunities to influence policy, some CHAM informants expressed concerns that the increased cooperation with the government may undermine their identity, and erode their specific attributes including their ability to adapt to evolving circumstances in their catchment area. Similarly, Rookes (2010) has pointed out that, while CHAM facilities welcome this opportunity for funding from government through SLAs, they are concerned about the potential constraint of their autonomy and an incremental slide to co-option, whereby they become merely an extension of the public health care system. The Malawi council of churches has pointed out that,

*“Some CHAs feel that CHAM is managing them and are intrusive, many people believe CHAM is an arm of government”*

(Malawi council of Churches, in Rookes (2010), page, 3)

#### ***7.2.2.6 Inadequate fiscal resources***

There is general perception that there are inadequate fiscal resources for implementing SLA activities in the health sector (for purchasing/obtaining drugs, medical supplies, equipment, services and human resources required to provide SLA services). During the research, fiscal resources emerged as one of the main challenges identified by various stakeholders of SLA. Within this broader challenge of fiscal resources, respondents identified three main concerns:

- Prioritization of financial resources
- General lack of financial resources

- Concerns about sustainability

Overall, most respondents who referred to prioritization of financial resources within or between government agencies and CHAM felt that the prioritisation was a greater challenge at the implementation level than at policy level. CHAM informants alleged that Ministry of health officials at the central level had SLA payment as a priority, but claimed that officials at the district level prioritised other activities such as servicing previous debts and buying fuel. The impact of this seeming conflict in prioritisation between those at policy and implementation level is thought to be delayed payments and accumulation of SLA debts by DHOs, leading to suspension of SLA contracts, non renewal of contracts and shortage of drugs and essential medical supplies. Bearing in mind that shortage of drugs and essential medical supplies can affect the way people access health care services, financial resources prioritisation may have some implication for health services provided under SLA.

Furthermore, there was also a general perception among respondents that there were not enough financial resources or financial resources earmarked for SLAs. Informants alleged that government did not anticipate that SLA utilisation would lead to high utilisation figures as witnessed in many facilities, which had exceeded the agreed ceiling levels. CHAM informants contended that, on both humanitarian and religious considerations, the facilities do not turn away sick people in order to operate within the ceiling imposed in the contract. Most of the facilities that were included in this study claimed that they had exceeded the ceiling set in the contract.

While the ceiling levels work as a mechanism for allocating resources by Ministry of Health officials, CHAM informants claimed that it was a sign that government had not enough financial resources to fully implement SLAs. The claims by CHAM informants were related to concerns by some Ministry of Health officials who argued that there were many SLA contracts in the country, such that there was need to reduce the number of SLAs. CHAM informants suspected that this perspective may be driven by inadequate financial resources. The perception of CHAM informants, that the government had insufficient financial resources for SLAs and Ministry of Health officials' intentions to reduce the number of SLAs, may potentially explain the delays in and non-payment of invoices by government and reluctance by some CHAM facilities to sign SLAs. This state of affairs was suspected to constrain the way SLAs were functioning in CHAM facilities.

In addition to the general perception of lack of financial resources for SLA activities, both CHAM and DHMT informants alluded to issues of financial sustainability in this policy intervention. Sustainability here refers to the long-term maintenance or continuity of the SLA policy instrument or how the SLA will remain productive over time. There are two important dimensions to sustainability in SLA. First, the SLA must be based on resources that will not be exhausted within a period labelled the long-term, and second, the SLA process must not generate unacceptable externalities. One DHMT respondent specifically identified sustainability as the major resource challenge and pointed out that,

*“you can negotiate all these contracts and get CHAM facilities to implement SLA activities, and then all of a sudden, funding is reduced, and you have to, just literally, walk away”* (DHMT informant)

Thus, there were concerns that SLA contracts that had successfully been set up could be undermined by a lack of provision for sustainability for example if donor funding through the SWAp basket was discontinued or reduced. These fears were realised between July 2011 and June 2012 when the United Kingdom withdrew aid worth £19 million, followed by the United States of America government which suspended an aid package of US\$350 million, and other major bilateral and multilateral donors who joined the UK and USA governments (The Guardian, 14 July, 2011). Even though aid to Malawi by some DPs has resumed, there is no guarantee that this shall always be the case. This entails that the issue of sustainability is still unresolved, and may re-surface again, with implications for SLAs.

#### **7.2.2.7 High staff turnover**

High staff turnover at most of the district health offices, especially those working as DHO, was seen as an obstacle to working relationships with government. CHAM informants specifically cited the disruption caused in SLA service provision when a team fragments and pointed out that,

*“It is sometimes difficult, you have a DHO that was involved in the negotiation of an SLA and that you build a relationship with, who you know can ring up, sometimes; this DHO is transferred to another role within the Ministry and is replaced by a*



*new person. In sense you take a few backward steps before establishing a new relationship and start moving again, and that can cause difficulties or service disruptions”.*

(CHAM respondent)

The challenges of political and economic instability, bureaucratic processes, concerns about loss of autonomy, fiscal resources, organisational differences and staff turnover as articulated in this section are thought to have contributed to information problems, delayed payments, outstanding disputes on prices and renewal of contract and numerous meetings to address outstanding issues. There are indications that these challenges have constrained the performance of CHAM facilities in delivering health services under SLA.

### **7.2.3 Government constraining DPs**

This sub-section explores the actions and behaviour of the Malawi government which are thought to be constraining DPs in pursuing their objectives. DPs are constrained by various structural, political and economic challenges present in the country. For instance, the formal public health system is dysfunctional: capacity and institutional environment and incentives are lacking (Kadzamira et al 2005; DFID, 2010; GIZ, 2012; USAID, 2011; NORAD, 2009).

One of the major constraints for DPs is the limited capacity in the country's public sector. Most DPs perceive capacity as a serious constraint to the effectiveness of their development initiatives. There are three components of the capacity which directly constrains DP activities:

- Institutional capacity - inadequacy or lack of policies and strategies and implementing tools to ensure efficient coordination and management of development assistance
- Human skills capacity - inadequate or nonexistence of skilled, trained personnel in place to implement policies and strategies and maintain the government- development partner interface
- Economic/structural capacities- the capacity of Malawi's economy to absorb additional development assistance with minimal macroeconomic distortions or “Dutch disease”, and to take on responsibility in the longer term.

In addition to capacity problems illustrated above, there are accountability and transparency issues in Malawi which are thought to constrain the flow of development aid. Given that most

DPs are accountable to their own citizen; they are not prepared to put funds through corrupt public systems. For instance, the German government pointed out that it was impressed with the reforms that the new government had undertaken, in particular on good governance and respect for human rights. Nevertheless, they cautioned that,

*“However, concerns over accounting systems including the audit office’s independence make it difficult to commit German taxpayer’s money through budget support”*(A statement by Thomas Staiger, Germany Economic Planning and Development Department desk officer, for Malawi and Zambia, Reported in Malawi News, 8<sup>th</sup> September, 2012)

In addition to the concerns at the national audit office (NAO), the German government is also not satisfied with the work of the Anti-Corruption Bureau (ACB) and other institutions that are established to ensure public sector accountability. The German government and other DPs have demanded reforms at ACB and NAO before resumption of aid for budgetary support. Suspension of aid by DPs due to factors outlined is perceived by DPs as disruptive for activities and processes, particularly with regards to programs that directly benefit from such funding.

Similarly, the Chair of Malawi’s donors common approach to budget support, has pointed out that,

*“As we all know, budget support was put on hold in 2011, due to lack of progress in addressing concerns on a number of underlying principles required for the support, as they are laid down in the Joint Framework agreement. These principles include commitment to sound macroeconomic management, commitment to good governance – including sound public financial management, accountability and effective anti-corruption programs – as well as respect for human rights, democratic principles, and the rule of law.”*

(Statement by the Chair of Malawi’s donors- Common approach to budget support –CABS, 2 October, 2012)

The foregoing implies that the seeming non action by the Malawi government in addressing issues highlighted above constitutes constraints to DPs’ capacity to pursue their objectives.

Important to this study is that these constraints and the response of DPs to withdraw support have implications for the provision of health services.

#### 7.2.4 DPs constraining government and CHAM

By offering development assistance, a DP advances its objective. When these do not coincide with the objectives of the recipient government, the DP may provide incentives or disincentives to persuade the recipient government to align its objectives with those of the DP. For instance, if the recipient government deviates by spending too little on DP preferred policy interventions, the DP might use access to or the threat to withdraw foreign aid as a carrot or a stick respectively, to induce particular behaviour in the recipient government.

So, in circumstances where the recipient government persists to deviate, DPs may be triggered to terminate or reduce development assistance. In so doing, the DP constrains the recipient country by conditioning future development assistance on the policy action of the recipient country to undertake DP favoured initiatives, as non-compliance to such demands leads to withdrawal of aid. There are numerous and recent instances whereby DPs have constrained the Malawi government by withdrawing aid. There is evidence that DPs constrain the government of Malawi through various mechanisms, including withdrawal of aid for the national budget. For instance, DFID (2011) has stated that,

*“Malawi will no longer receive general budget support from the UK government.... This has now been suspended indefinitely. The development secretary took the decision after the Government of Malawi repeatedly failed to address UK concerns over economic management and governance”*

DFID contends that the decision to suspend aid was in line with international concerns over Malawi's failure to implement sound macroeconomic management programs and address governance issues. Considering that these problems had existed in Malawi since the second term of President Mutharika's government, and that the UK government continued to support the general budget, it implies that macroeconomic and governance issues were not the primary concerns of the UK government such that they could lead to the withdraw of aid. Bearing in mind that the decision to suspend aid only came after the British high commissioner to Malawi was expelled by the Mutharika's government for reasons that could be considered as political, we can construe that the withdraw of UK aid to Malawi was a

direct reiteration for the expulsion of the high commissioner and not necessarily due to macroeconomic mismanagement and governance problems as presented by DFID. Despite geopolitical reasons for UK withdrawal of aid as outlined here, other development partners including: World Bank, the European Union, the African Development bank, Germany and Norway all followed the UK and suspended or ended general budget support to Malawi.

Malawi is very dependent on DPs to finance its public expenditure and balance of payments. Around 23% of Malawi GDP and up to 80% of the government's capital budget are financed by DPs (Whitworth, 2005). Consequently, DPs withdrawal or suspension of development support as highlighted here interferes with and constrains numerous programs in the Malawi economy. For instance, contracting out of health care through SLA has been possible due to financial and technical support provided by various DPs through SWAp. However, given that DPs cannot guarantee long term funding of a country's activities through aid, this presents uncertainty challenges in the planning of SLA activities. One government official commented that:

*"There's no point in planning for three years if you can't even plan for six months. If suddenly 50% of the money doesn't come, there's really no point."* (Leiderer et al 2007, Page 107)

The uncertainty in the planning stems from the unpredictability of DP funding, for instance due to recession in home country, changes in priorities when government changes and bureaucracy, that often creates special challenges to the Malawi government in terms of economic management including fiscal volatility and budget deviations. These result in cutbacks in various sectors of the economy, including health, with implications for policy interventions such as SLAs. Aid unpredictability as outlined here might have a detrimental effect on institutions. IDD and Associates (2005) claimed that:

*"When external funding is delayed or does not materialize at all, the government may be required to turn to ad hoc solutions such as domestic borrowing, or cutbacks of planned expenditure and deviation of funds intended for different purposes, undermining macro-economic stability and budget credibility."*

(IDD and Associates 2005, page 18)

NGOs play an important role in promoting good governance, transparency and accountability, however, DPs channelling of large sums of aid through NGOs and not the national budget is equivalent to supporting the demand side while ignoring the supply side. In that, most NGOs concentrate on empowering the population to alleviate social needs, thereby increasing demand for public services but do not invest in training of skilled professionals, development of long term infrastructure and institutions that will enable the empowered population to access better quality services. For instance, NGOs may provide health vouchers that will encourage people to access health care in public facilities that are dysfunctional due to shortage of skilled personnel and infrastructure to support the provision of quality health services.

Most NGOs have little capacity at the outset, but using financial resources from DPs, they are able to attract highly skilled personnel from the public sector by offering them higher salaries and perks than the government pay. The NGOs are therefore able to by-pass central and local government administrative structures, and often weaken these structures further and render the public sector non- functional. For instance, the Chair of Malawi's donors pointed out that,

*“As you know, when budget support was put on hold, we continued our support to Malawi in other areas and relocated grants to areas facing special challenges”*

(Statement by the Chair of Malawi's donors- Common approach to budget support – CABS, 2 October, 2012)

The grants in this case were removed from the national budget support to DP organisation and NGOs, to implement activities that were originally going to be implemented by government through the national budget. MHWO (2010) has pointed out that,

*“Non-governmental organizations (NGOs) in Malawi's health sector include international and national bodies scattered all over the country. This is partly a by – product of the need for donors to channel large proportions funds to the Malawian population through non-government health providers rather than the MoH per se as some donors, particularly certain bi-lateral donors, believe these providers yield more immediate and visible results as they work close to the population”*

(MHWO, 2010, page, 61)

In addition to employing government employees in their organizations and through NGOs, DPs are also involved in training activities and workshops which attract public sector employees because of the monetary incentives that such training and workshops provide. These activities therefore contribute to absenteeism at government institutions, thereby exacerbating the shortage of skilled personnel in the system. Mueller et al, (2011) have pointed out that:

*“National level stakeholders were also not surprised at the high number of absent days due to training and meetings. Some donors recognised that they contributed to the frequency and volume of the training activities”* (Mueller et al 2011, page, 5).

Another important constraint pertains to DPs systems and procedures in implementing their development support activities. Some DPs internal systems and procedures are complex and inflexible and work against collaborative work with the Malawi government’s existing systems. Some of the procedures require the most experienced staff, who understands how the DP procedures should work, and how they can be adapted to work effectively in Malawi. Leiderer et al. (2007) have pointed out that,

*“Donors exacerbate ... capacity constraints through poorly harmonized procedures and control requirements, thereby generating confusion and additional workload for the domestic administration. With virtually all major donors operating in Malawi, it seems to be difficult for Malawian stakeholders to know, understand and follow all different procedures and mechanisms required by different donor agencies. Especially stakeholders at the local level find it particularly difficult to understand...”*

(Leiderer et al. 2007, page 109)

The actions and processes of DPs presented in this section are construed as constraints to the actions of the Malawi government, and this has implications for various policies including those intended to promote health care delivery like SLA. Considering that the Malawi government relies on DPs to support the national budget, DPs are able to shape the incentives and the actions of the government through withdrawal of or threats to withdraw development assistance towards the national budget. Similarly, due to the dependence of CHAM facilities on government financial resources through the MOU, SLA and various other mechanisms, the government is able to shape the incentives, control and manage CHAM activities.

### 7.3 Conclusion

In this chapter, I have illustrated the presence of multiple agency relations in government, DP organisations and CHAM as well as identified various challenges associated with multiple agency relationships in SLAs. The challenges encountered are centred around how the actors reshape each other's incentives through various mechanisms such as bureaucratic systems, unpredictability of financial flows and capacity problems. Some of the mechanisms used to reshape incentives as described here act as constraints and raise concern about the effectiveness of SLAs. This suggests that, the failure to achieve intended SLA policy outcomes, is not entirely due to lack of knowledge about the process and outcome among health care managers and decision makers, but rather optimizing agents face incentives and constraints that deviate their behaviour from the intended actions and outcomes.

The results suggest that, by constraining each other, the stakeholders under each of the three major categories (government, donors and CHAM) exert some influence over resource allocation in SLA. Given that the relationship between these actors was analysed using the principal agent framework, the expectations were that those actors considered as principals, will have control over resources, and will be able to impose penalties that will shape the incentive environment of their agents. However, the results indicate that despite having the right to impose such penalties and constraints, the principals did not impose penalties on their agents, but compromised and continued working with them. This challenges the principal agent framework in that, principals avoided imposing penalties on their agents, fearing that doing so would impact negatively on their political and economic objectives. For instance, despite breaches of human rights and economic mismanagement by the Malawi government, DPs compromised and continued to support the national budget. This shows that the actors have some influence in the relationship, and that they can influence the outcome of the policy, even though they may not directly control the budget as a principal.

The next chapter will provide a discussion of the results of the research, particularly focusing on broad themes that guided the research i.e. the implications of SLA contracts for access, equity, quality and efficiency, how effectively SLAs were implemented, how CHAM facilities and DHOs responded to its mechanism, and how the discrepancies of demand and supply factors impacted on the provision of health care services. The chapter will also discuss the involvement of DPs and explore whether SLA is a donor driven idea and who want SLAs to work.

## Chapter 8: Discussion

### 8.0 Introduction

This discussion aims to concentrate on the broad themes that guided the research i.e. the implications of SLA contracts for access, equity, quality and efficiency. The discussion is organized to address the subthemes that guided the study, and is structured in 3 sections.

- 1) The first discussion aims to draw generalizable implications for adapting, designing and implementing SLA contracts as a policy tool for improving health system performance. This section of the discussion also compares the observed pattern of response behaviour predicted by economic theories of principal agent and transaction cost economics.
- 2) The second discussion relates to how SLAs were implemented and what has been learnt. This covers contractual obligations and performance within the broad objective of SLA between CHAM facilities and government agencies; how effectively SLA was implemented, how CHAM facilities and DHOs responded to its mechanism and how the discrepancies of demand and supply factors impacted the provision of health care services.
- 3) The third discussion is focused on elaborating whether SLA is a donor driven idea or Malawi government owned. This is necessary owing to the involvement of DPs in the Malawi health sector, their influence, how they shaped the incentive environment of government and CHAM, the challenges of donor dependency and their implications for the sustainability of health care financing in the country's health system. Important questions posed in this section are; Is SLA a donor driven idea? Who wants SLA to work?

### 8.1 Applying principal-agent and transaction cost economics theories in SLA

The study used the theoretical models of principal agent and transaction cost economics to understand the context and influences on both implementation and effects arising from SLAs. By virtue of the government contracting out health care provision to CHAM facilities, there is a contractual relationship and a transaction, to which principal agent and transaction cost



economics models can be applied respectively. In identifying principal - agent relationships, the thesis relied on the flow of financial resources and interview data with policy makers, DHOs, facility managers and frontline health care providers. Principal agency relations were traced at three levels: upstream relationships between MoH and district health office officials, midstream between district health office and CHAM facilities and downstream between CHAM facilities and frontline health care providers.

The basic assumption of the principal agent model is that the outcomes of contractual relationships depend not only on inputs, but more crucially on the behaviour of the purchaser and provider, particularly through their objective function, information and incentives. All other factors that influence the contractual process do so because, and in as far as they influence the behaviour of the purchaser or provider. The theory recognizes the presence of multiple agency relations as well as the multiplicity of possible factors, and seeks to understand the objective function, information distribution, and incentives of the contracting parties.

The principal agent relationship between district health officials and CHAM facilities emerged from two perspectives. While both CHAM facilities and district health officials claimed to share a common objective of providing maternal and child health care services to a needy population, this contrasted with an understanding of varying 'revealed' objective functions of CHAM facilities, government agencies and development partners which contained a range of arguments. The objectives of the government, DPs and CHAM were key factors in explaining and understanding access, equity, quality and efficiency of healthcare services offered through SLA, as the objectives affected the relationship between CHAM facilities and district health officials. The decision by district officials to contract out CHAM facilities exposed an agency problem. CHAM facilities were consistently accused of inappropriate claims by inflating utilisation figures and over prescribing medication. Due to weak monitoring and evaluation district health officials were unable to ascertain whether the person treated under the SLA arrangement warranted the service e.g. allegations of 'ghost' patients in some facilities. CHAM facilities on their part argued that the district health office did not provide the requisite services for SLA patient's e.g. timely transport for complicated cases to get to referral facilities and provision of essential drugs and medical supplies. The foregoing indicates that there were information asymmetries which resulted in uncertainty and mistrust between CHAM facilities and government agencies. The implications of the

uncertainty and mistrust are reflected in the difficulties in the implementation and management of SLAs.

In addition to varying objective functions, by contrasting the stated and revealed objective functions of CHAM, government and DP agencies in relation to SLAs, the results from the contracting out policy indicated that some revealed objective functions within CHAM, government and DP agencies as well as between government, CHAM and donor organisations are contradictory. The contradictions between stated and some of the revealed objectives partly explain the challenges faced in the implementation of SLA. For instance, there were indications in some cases suggesting that the objective of CHAM facilities in providing health care services included generating financial resources that could be used to pursue and promote their missionary activities, and not strengthen the health system. Similarly, there were indications suggesting that government objectives included political, and growing public sector activity rather than to achieve population health objectives. The actions of development partners imply that their objectives include visibility, attribution, commercial and political influence, and seemingly not only strengthening the health system. The problem of conflicting stated and revealed objective functions among SLA actors was exacerbated by the presence of multiple agency relationships within CHAM, government and development partners.

The analysis of multiple agency relations in government, DP organisations and CHAM, involving various actors with disparate stated and revealed objectives, provided an understanding of how these actors shaped each other's incentives. The lessons learnt are centred on how the actors reshaped each other's incentives through various mechanisms such as bureaucratic systems, unpredictability of financial flows and capacity problems. Some of the mechanisms used to reshape incentives as described here, had unintended consequences or side effects which acted as constraints and raised concern about the effectiveness of SLAs. For instance, the suspension of aid by DPs to ensure that the Malawi government adhere to sound macroeconomic principles, affected the government budget, an action which evidently affected the financing of SLA activities. This suggests that, the failure to achieve intended SLA policy outcomes, is not entirely due to lack of knowledge about the process and outcome among health care managers and decision makers, but rather optimizing agents face incentives and constraints that deviate their behaviour from their stated objectives and intended outcomes.

The foregoing suggests that, by imposing some constraints on each other, the stakeholders under each of the three major categories (government, donors and CHAM) exert some influence over resource allocation in SLA. Given that the relationship between these actors was analysed using the principal agent framework, the expectations were that those actors considered as principals, would have control over resources, and be able to impose penalties that would shape the incentive environment of their agents. The results indicated that CHAM facilities and government imposed such penalties and constrained each other. For instance, the Ministry of Health did not pay some facilities and some CHAM facilities ceased providing SLA services. However, in some instances the penalties were not strictly adhered to, owing to political and economic considerations embedded in CHAM and government relationships. This challenges the principal agent framework in that, both CHAM facilities and MoH did not impose strict penalties on each other, fearing that doing so would impact negatively on their economic and political objectives respectively. The foregoing is a reflection on the market structure i.e. single buyer and single provider. This is further explored on page 197.

Similarly, in the seemingly principal-agent relationship between DPs and government, the two parties applied penalties on each other to influence behaviour. However, as in the CHAM government scenario, DPs and government in some instances did not apply the penalties strictly, but compromised. For instance, despite breaches of human rights and economic mismanagement by the Malawi government, DPs compromised and continued to support the national budget, instead of penalising the government by withdrawing aid.

### **8.1.1 Transaction costs in SLA**

The aim of this section is to tease out the nature of the elements of transaction costs involved in the administration of SLA contracts between DHOs and CHAM facilities. As explained in chapter 3, transaction costs may arise due to bounded rationality and opportunism of either party to the transaction. SLA involves contracting between government agencies and CHAM facilities under conditions of imperfect information. The economics of contracting is based on transaction costs which arise from the costs of seeking out purchasers and providers, arranging, policing and enforcing contracts in an environment characterized by imperfect

information. Three concepts related to imperfect information are bounded rationality, opportunism and asset specificity. These are discussed next in relation to SLA contracts.

#### **8.1.1.1 Bounded rationality in SLA**

Bounded rationality recognises the cognitive limitations of the human mind to completely evaluate all consequences of possible decisions and future contingencies. In the context of SLA, the impact of bounded rationality was demonstrated in part by the knowledge and skills CHAM facilities and government agencies had in specifying, selecting appropriate contract partners and managing as well as controlling the relationship.

For instance, one of the most important factors in the contractual relationship between CHAM and government was the price of SLA activities. There was a general observation that the prices of contracted services increased sharply after SLA contracts were signed due to inflation and devaluation of the Malawi kwacha. Failing to provide for this eventuality reflected bounded rationality in the periods prior to contracting-out. According to the theory of bounded rationality, the complexity and uncertainty associated with long-run decisions does not allow a complete specification of the problem at hand. Since information is costly and the decision process cannot go on indefinitely, the result of bounded rationality is that agent's *satisfice*, that is, they stop at whatever decision rule meets the minimal requirements. In the case of SLA contracts, the currency crisis came in August 2003 when the currency was devalued by 35%, followed by another devaluation of 30% in March 2005. In terms of US dollar, the exchange rate rose from K60 to K108, between June 2002 and August 2003. The stability of the Kwacha however only lasted until March 2005 when a series of adjustments saw the Kwacha resting at K123 against the US dollar (Simwaka, 2011). The initial responses of the reserve bank of Malawi were substantial increases in its base interest rate to fight devaluation and reduce its pass-through to inflation. The responses of the reserve bank led to inflation, especially on goods/services that used imported materials, including drugs, medical supplies and transportation costs.

In addition to prices, utilisation of SLA services in most CHAM facilities was higher than anticipated by both government and CHAM. The consequences of misspecification, inability to predict changes in the economy, specify utilisation figures, contract inappropriate health care providers and failure to manage as well as control the relationship have been contract

renegotiations and termination. These consequences generate extra costs that can be classified as transaction costs.

#### ***8.1.1.2 Opportunism in SLA***

The conceptualisation of opportunism posits that people act in self interest with guile; this is mostly due to incomplete or distorted disclosure of information which results from “calculated efforts to mislead, distort, disguise, obfuscate or otherwise confuse” (Williamson, 1985, pp.47-48).

This suggests that either party to a contract can use loopholes in the contractual relationship to their advantage. In the context of CHAM facilities and government agencies in SLA, there are signs of opportunistic behaviours being pursued by both parties. This opportunism may prevent implementation of the policy program by another party, for instance the resistance of some DHOs to enter into SLA agreements, despite central level official approval of the policy. This is likely to occur if those at the implementation level suspect that implementing the policy may erode their authority or otherwise undermine their interests. This was observed in the reluctance of some government agencies to work in harmony with CHAM facilities, rather than to concentrate on growing the public service with a view to expand their influence.

Similarly, opportunism on the part of CHAM was manifested in the practice of inappropriate numbers provided for payment and through overcharging government for transport as claimed by government informants, while from the government side, opportunism was manifested in the delay and non payment of SLA bills in the full knowledge that facilities have provided the services. In addition to this, government agencies had capped prices and delayed payments in full knowledge that most CHAM facilities will continue to contract with government, as there are few or no alternative purchasers of their services.

Both CHAM facilities and government agencies understand their organizational roles in implementing the SLA policy but given that individuals representing the two organisations may have objectives different from those of the organisation they represent, they act in ways that prevents effective implementation of SLA, through non- payment or renewal of SLA contracts as illustrated in the results chapters. Examining the multiple agency relations within which the SLA policy is implemented it is easy to observe and identify agents that behaved

opportunistically and prevented proper implementation of SLA by acting in ways that constrained the contracting out policy.

The result of bounded rationality and opportunism as illustrated here is the probability that a party to a contract, CHAM facilities or government agencies will exploit their information advantage. This implies that the imperfect information in the SLA contract enabled CHAM and government to operate opportunistically by exploiting any information asymmetry (e.g. about the true cost of services or quality of services provided).

#### ***8.1.1.3 Asset specificity in SLA***

Opportunism in a contractual relationship like SLA becomes a threat particularly due to asset specificity. While it was relatively straight forward to approximate the transaction cost attributes of opportunism and bounded rationality to SLA contracts, the adaptation of transaction cost attributes of asset specificity was not. To capture asset specificity, the thesis used information on the reported investment by CHAM facilities in the existing and additional infrastructure required to provide SLA services. The seeming reluctance by government to review prices and renew SLA contracts, but not explicitly stop people from demanding SLA services from CHAM facilities which had expired SLA contracts, point to the holdup scenario that is often associated with asset specificity.

Williamson (1985) highlighted asset specificity as a prime condition for “holdup” in contracting. In the context of SLAs, CHAM facilities have no immediate alternative party with whom to contract without net costs that equal or exceed those resulting from acceding to the opportunistic government demands. For instance, the existence of specific assets in SLA contracts such as the investment by CHAM health facilities in infrastructure resulted in opportunism and increased transaction costs, in the sense that, CHAM facilities capacity (infrastructure) has a significantly higher value within SLA contracts than outside SLA. This is so, as most CHAM facilities are located in remote and rural areas, where there are less or no commercial activities that can utilise the infrastructure, other than the public sector. Therefore, if government decided to stop all SLA contracts, CHAM facilities capacity used for SLA could not immediately and costlessly be transferred to the production of alternative services. The difference in value within and outside the SLA relationship is equal to the SLA specific element of CHAM facility assets.

The economic relevance of specific assets is that they create the potential for opportunism through hold up. For instance, after some CHAM facilities have made their SLA specific capacity investments (e.g. extra children and maternity wards as reported in chapter 5), government could threaten to stop SLA contracts with CHAM facilities and impose a capital cost on CHAM facilities equal to the value of the SLA- specific elements of CHAM facilities' capacity investment. Given that government knows that CHAM facilities cannot immediately and costlessly transfer their capacity to alternative use, government agencies have, in principle capped prices, by negotiating to maintain the 2006 prices of SLA services. Consequently, because CHAM facilities expect that they may lose a share of the return on their specific investments if they withdraw, this has resulted in a hold up. One of the economic costs associated with holdups involves the reduced incentive of both CHAM facilities and government agencies to make efficient SLA contractual relationships, For instance, government not prioritising resource allocation towards a mechanism that may help streamline the prevailing challenges in SLA contracts, including monitoring and evaluation.

Some of the elements that were thought to be generating transaction costs in SLA contracts were acknowledged as: the cost of time staff spent attending meetings and briefings, travel costs, accounting and legal fees, consultancy fees and transitional costs such as the setting up of HMIS and staff training. The staff cost is attributable to preparation and negotiation of contracts and was mostly reported by CHAM facilities as being the most significant cost. However, the most noticed transaction cost element for all parties involved appeared to be the opportunity cost of time spent by both management and physicians in gathering information prior to and during the contract negotiation phase.

The bureaucratic nature of the SLA process entails that the opportunity cost for some professionals is high. Since the cost of time spent in meetings by various actors does not form part of the cost of the contracted services under SLA, the opportunity cost of time as presented here may be considered as a transaction cost. Following from this explanation it is possible to discern that time is among the main types of transaction costs; while the others are information search costs, bargaining and decision costs, policing and enforcement costs, as all these activities involve time. Negotiation for SLA contracts is in most cases prolonged, implying that SLAs are generating significant transaction costs.

Despite their seeming presence, transaction costs were largely overlooked in the proposal to involve private health care providers through contracts, especially in SLA policy design to contract out CHAM facilities to provide maternal and child health. Although transaction costs can occur during contracting (period 1) or post contractually (period 2), it is usually not feasible and practical for the contracting out parties to address both types of cost at the initial contracting stage (period 1) due to bounded rationality. The equilibrium or outcome in this case typically does not maximise access or efficiency.

## **8.2 What has been learnt from SLA contracts?**

The substantive discussion in this section is related to how SLAs were implemented and what has been learnt through their implementation. The discussion covers contractual obligations and performance within the broad objective of SLA between CHAM facilities and government agencies; how effectively SLA was implemented, how CHAM facilities and DHOs responded to its mechanism and how the discrepancies of demand and supply factors impacted the provision of health care services.

### **8.2.1 Contractual obligations and the response of CHAM and government**

Contractual obligations entail performing what the parties to a contract agreed to do in the contract, while response is the change in actions or behaviour of either party after the contract has started due to incentives or disincentives provided in the contractual relationship. From a principal agency perspective, incentives or disincentives refer to factors that a principal can include in a contract to influence the behaviour and response of an agent toward the principal's objective. Rational actors respond powerfully to both incentives and disincentives. Incentives as explained here are vital in the functioning of contracts. However, an individual or group of individuals representing the principal can alter the incentive structure to achieve personal objectives, in ways that may interfere with the attainment of organizational objectives.

It is therefore imperative to understand the nature of such incentives and who is empowered to implement a policy and to what degree they can implement it. For instance, the SLA mechanism provides an incentive to CHAM facilities by payment of SLA invoices. However, because of the bureaucratic nature of the Ministry of Health, individuals relatively low in the



formal bureaucratic hierarchy often have a great influence on resources, these individuals prioritise other activities and delay payment of SLA fees. Examples include DHOs who override the requirements of senior level officials on SLAs, because the DHO has been empowered by the Ministry of Health to implement the SLA policy.

In contrast, despite being empowered through the bureaucratic hierarchy, some DHOs feel that they have limited scope to fully implement SLA activities, such as; renegotiation of prices with CHAM facilities, or renewal and termination of SLA contracts when there was evidence that acting so would result in a better outcome. Furthermore, in public sector interactive processes like SLAs, informal sources of incentives through politics and connections with those in high offices may be highly important and, in many cases, can balance the more formal incentive structures of the implementing authorities, such as by bypassing DHOs in deciding which facility is to sign a SLA with government.

In addition to incentives, the interaction between CHAM facilities and government must be considered further to analyse barriers to implementation of SLA due to information asymmetry. There are two types of interactions that have been observed in the contractual relationship: active cooperation between government and CHAM facilities has been observed when both parties share common goals, such as the provision of health services to the under privileged. However, in some cases there has been “passive aggression” in that both parties have adopted a relatively passive approach to the implementation of the SLA policy instrument. One example is government neglecting payment of SLA bills and renewal of SLA contracts, but not explicitly informing the beneficiaries of SLA services to stop going to CHAM facilities. Furthermore, in some SLA contractual arrangements the interaction can best be referred to as forced cooperation, as cooperation is imposed by each party based on their control in the contractual relationship. For instance, CHAM facilities may pressurise government to commit through renewal of SLA contract and price reviews, by threatening to suspend provision of SLA services. Similarly, government may threaten to withdraw salary, medical supplies and training support from CHAM institutions if they decide not to provide services before SLA is signed or decide to suspend /terminate SLA services.

Furthermore, it is important to recognize that relationships between actors in a multiple agency relationship as presented in this thesis entail different levels of interdependency. Principal agency theory suggests that improving implementation in a contractual relationship

may not require large scale efforts throughout the entire chain of principals and agents, but rather well focused incentive structures that create small changes among a few agents that are part of the multiple agency relationships (Itoh, 1991; Gibbons, 2007).

### **8.2.2 Disputes and renegotiations**

Following from the principal agent model which postulates that the principal and agent may have varying objectives and incentives, disputes and renegotiations are inevitable. To dispute is to question the truth or validity of a particular issue if the other party believes or has reasons for wanting to claim that it is inaccurate as the case has been in circumstances where government agencies representing the Ministry of Health have disputed the number of people utilising SLA and the invoices that CHAM facilities have presented to them for payment. On the other hand renegotiation involves revising the terms of a contract and surplus sharing by parties in a contract (Edlin and Hermalin, 2000). Most SLA contracts are disputed and renegotiated within months (GIZ, 2010). CHAM secretariat informants claimed that government disputes some of the figures presented by CHAM facilities. Similarly, public sector interviewees claimed that most renegotiations are initiated by CHAM facilities and end up in their favour, resulting in increase in tariffs and more expenditure by the government.

There are various causes of conflict in the contracting out of health care services under SLAs. Some of these causes are specific to facilities while others are general to all SLA contracts. For instance, in some cases, CHAM facilities are alleged to have submitted aggressive and opportunistic plans forcing government agencies and Ministry of Health officials to renegotiate later. In most cases, contract renegotiations involve either party to the contract seeking to reduce their risk but increase their utility with a reduction or no change in their obligations. For example, CHAM facilities may seek to reduce risk, increase tariffs and establish an automatic tariff review process that responds to the change in agreed indices without regulatory evaluation and verification of impact of costs by government (pass-through costs). The government on the other hand often focuses on the attainment of expansion goals. Quite often the government is unable to agree to tariff increases for fear of overrunning their budget, despite available evidence of price increases in drugs and medical supplies, which are among the essential inputs of SLA services.

The foregoing implies that, if SLA contractual agreements between government and CHAM facilities were instituted without rigorous analysis of their implications for renegotiation, they are likely to be unsustainable. For instance, non-payment of bills by government, unrealistic SLA prices and inaccurate predictions of utilisation, have led to renegotiations between government and CHAM facilities. Frequently such renegotiations involve considerable disruption of SLA services as shown in several case study sites. The disruption of services due to non-payment can lead to people using unsafe sources of health services such as TBAs or reverting back to user fee mechanisms with consequences of impoverishment.

Importantly, the resolution of contractual conflict between the Ministry of Health and CHAM facilities is not only a legal or administrative process, but a political one which often involves normative judgement. The political sensitivity of health care service supply is particularly evident in incidents involving deterioration in the quality of healthcare services being provided. Depending on the interests of the politicians, they may ignore the situation or act quickly to resolve the dispute.

### **8.2.3 The interaction of demand and supply side factors**

Although demand side factors are the prominent features of SLA, this section considers the joint effect of demand and supply side changes in formulating predictions about usage change due to SLA. Specifically, how supply factors have limited SLAs' ability to significantly improve utilisation and access to contracted-out services.

Evidence from various documents cited in this study, suggests that the implementation and analysis of health care service delivery through SLA has mainly focused on the demand side, in particular user charges, while issues related to resources, capacity, institutions, incentives and behaviour of purchaser and providers have received much less attention. However, if health care contracts like SLA are to work, there is need to use micro approaches to analyse the delivery of health care services under SLA from the supply side and determine ways to strengthen the supply side factors in order to maximise the benefits of contracting out. These approaches to strengthen supply side factors in health care warrant further research because they may be potent alternatives to the dominant demand side approaches, which seem to have failed to maximise the potential of contracting out, particularly in low income settings. The focus should be on the interaction between demand and supply factors, along with the

behaviour of CHAM facilities and government agencies as well as the constraints associated with supply side shortcomings (Gauthier and Reinikka, 2007).

The foregoing suggests that reducing financial barriers by using mechanisms such as SLA makes no sense in the absence of services of adequate quality due to the use of unskilled staff, shortage of essential drugs and medical supplies and poor infrastructure. It is therefore important to note that the financial status of the patient is not the only determinant of the interdependency strategy needed to increase access; however it is the core component among the multiple factors that play a role in facilitating access to essential health care services. This implies that the removal of cost as a barrier through SLA alone would not necessarily ensure access to health care services, but highlights that approaches to reducing financial barriers should also be sensitive to supply side factors. Ensor and Ronoh (2005) have argued that, physical barriers, quality of care barriers and financial barriers are often interlinked. For instance, distance increases household access costs, health facilities which lack basic supplies create knock on effects on costs for households which have to purchase items externally.

Supply side factors were not properly considered during the planning and implementation stages and this led to delayed and non payment of SLA invoices, drug stock outs, low supply of skilled health workers, shortage of equipment and minimal infrastructure. This is reflected by the low number of CHAM facilities equipped and staffed with competent, available and committed personnel; and believed to cause women to prefer delivering through TBAs rather than embarking on a costly journey which may not improve outcomes. This partly explains the high rates of utilisation of antenatal clinics but low numbers of delivery at some CHAM facilities in the study.

Similarly, despite that services are free of charge under SLA, the time women spend waiting for delivery is seen as a deterrent due to lack of financial resources required to cover food and admission related expenses. Lack of financial resources as illustrated here, cause women not to come for delivery at health facilities. Women who utilized the services claimed that it was very difficult to raise enough money to pay for food while receiving health care at the health facility. This further affirms that user fees are not the only factor that impact on utilisation of maternal and child health services. The phenomenon of having more women attending antenatal care, but only few coming for delivery at the clinic is not SLA specific; it is common in most low income countries, mostly based on the reasons pointed out here.

However, the factors outlined above provide a picture of the implications of using SLA as a mechanism of providing health care services and how this affects the pathway to access, equity, quality and efficiency.

Contracting out of health care services focusing on technical requirements for access, equity, quality and efficiency and neglect of political economy considerations can lead to adverse consequences. The market structure in the health sector and particularly in SLA is thought to be both a monopoly and monopsony, and abuse of market power by both the buyer (government) and supplier (CHAM facilities) is possible.

Agents that find themselves in a monopoly provider /supplier relationship, regardless of an existing and well- constructed SLA contract structure, may find themselves better served by using the associated monopoly power to alter the prevailing arrangements favourably. Similarly, principals who are in a monopsony position, drive down market prices of inputs below competitive norms, pushing providers into loss making positions. The monopsonist reaps excess market rents. In the case of a government principal as in SLA, these excess market rents are viewed as a reduction in the overall healthcare cost.

The seemingly pervasive agency relationship involving a monopsony principal and a monopoly agent in SLA has some externalities, such that some actors in government agencies suspect that CHAM facilities are profiting from SLAs and that any renegotiation is a strategy to increase their surplus. Similarly, given that there is practically no direct competitor to CHAM facilities in the faith based sector; it is also clear that contracting out in the Malawi health sector is in its infant stage as most CHAM facilities are monopolies. The apparently monopolistic and monopsonic nature of SLA contracts may help explain some implementation challenges of this policy.

Similarly, the conflicts between CHAM and government in health care contracting have not been sufficiently addressed in the contract design and regulatory mechanism. The case studies provided some valuable evidence regarding the role of the ZONE officers who act as regulators. It was repeatedly asserted by CHAM facilities that Zone Officers lack independence and that their decisions were directly influenced by the Ministry of Health, their employer. As regulators, they were expected to inspect, investigate and where necessary take enforcement action. However, CHAM informants claimed that, they were biased or

influenced to back government as a result of their employment with the Ministry of health. This seeming conflict of interest by these regulators, inhibit open discussions or result in decisions, actions or inactions that are not in the best interests of both CHAM facilities' and government agencies. This, in turn, may have lead to perceptions that CHAM facilities/government agencies have acted improperly, and affected the contractual relationship.

On the contrary, DHMT informants claimed that in some instances CHAM facilities negotiated with Ministry of Health officials, by-passing the Zone officers and use MoH officials to pressurize Zone officers. Furthermore, there was also a tendency by some government officials at the central level to use Zone officers and DHOs as scapegoats in the process of dispute negotiation. For example, DHO and Zone officers were blamed for non-payment of SLA; however, in some instances the officials at the Ministry of Health headquarters were responsible for the delays and non-payment, by failing to transfer funds that were part of the district budget.

Based on removal of user fees through SLA as illustrated in this thesis, it is less evident that contracting out has improved the welfare of consumers by removing users fees; as user fees are typically not the only determining factor in deciding where to seek health care services. An important factor alongside price is quality. In the absence of better quality health care services in some CHAM facilities as illustrated in this study, it would be incorrect to generalize that contracting out through SLA has improved the welfare of the people in general. This is so due to the importance attached to quality of health care provision. It is therefore rational to assume that consumers of SLA will prefer a combination of user fee removal and better quality services; hence the removal of user fees and absence of quality health care services may have a negative impact on their welfare.

It is clear from the utilization of maternal and child health services at some CHAM facilities involved in this study that user fee removal and good quality services improved the welfare of those utilising the services. This substantiates the notion that a combination of user fee removal and better quality services through contracting out overall has positively improved the welfare of the consumers of maternal and child health services as advanced by WHO and the universal health care literature. However, we conclude by observing that significant welfare improving potential of contracting out health care services has yet to be fully realized. There are five main supply related factors that have been identified as constituting

bottle necks in the successful implementation of SLAs. These are institutions, human resources, infrastructure, drugs and medical supplies, and financial resources. These factors and their implications are discussed next.

### ***8.2.3.1 Institutions***

New institutional economics (Coase, 1937), shows that institutions matter. Coase (1937) and Williamson (1975) suggest that, institutions consist of legislation, regulations, and command and control approaches governing the operation of any economic activity. For example, a highly elaborate bureaucratic registration scheme might place enormous burden on the capacity of the state. Institutions form the basis on which private sector service providers are prohibited, permitted or encouraged to operate. Institutions can on one hand seek to suppress private sector involvement, on the other promote its operations (Carlson, 2007; Mcloughlin, 2008; Pavignani, 2008; Bartley and Mcloughlin, 2009).

Institutions are inherently political in nature, difficult to establish in contested situations where the state may lack adequate incentive or political clout, as such, weak and contested government authorities are not in a position to properly enforce institutions. Pavignani (2008) has suggested that public authorities prefer to drop the issue of institutions from the agenda and concentrate on service provision. Even in relatively strongly governed countries, there is evidence that capacity to regulate successfully – especially in relation to enforcement and monitoring, is weak (Pavignani, 2008).

In terms of SLAs, institutions refers to the recognized structures of rules and principles within which CHAM facilities and government agencies operate, including such concepts as enforcement, governance and accountability. There are indications from the results of this study that SLA relies heavily on the institutional arrangements of already existing programs, for instance, the memorandum of understanding between CHAM and Ministry of Health. It is thought that, the absence of a functional SLA institutional framework, to govern implementation, impact on its effectiveness. There are no functional enforcement and accountability mechanisms to deter either party from deviating from SLA objectives.

In addition, it is important to note and understand that, the seeming absence of SLA specific institutional structure has an impact on the functionality of CHAM facilities and government

agencies. The impact is mostly due to the additional administrative burden created by SLA in CHAM facilities and government departments, by assigning the already scarce skilled health personnel, enforcement, governance and accountability roles, instead of leaving them to concentrate on core healthcare issues.

Given the absence of institutional structure and varying incentives among the key actors, it is no surprise that SLA does not provide sufficient finances for institution development and investment in capacity building. For example, there has been no specific SLA related cost for technical support, training and salaries of regulatory body staff. In fact, there is no regulatory body to monitor and evaluate SLA activities. Monitoring and evaluation activities that are supposed to be conducted by the Ministry of Health had not been conducted at the time of the study.

#### ***8.2.3.2 Human resources***

Human resources entail the set of individuals who make up the workforce of an organization. In healthcare settings, human resources are termed human resource for health (HRH) or “health workforce”. WHO (2006) has defined human resource for health as people engaged in actions whose primary intent is to enhance health. Based on WHO (2006) definition, human resources in health are regarded as one of the core building blocks of a health system. They include medical doctors, midwives, nurses, dentist, allied health professionals, social health workers and community health workers, as well as health management and support personnel – those who may not deliver services directly, but are essential to effective health care functioning, including healthcare service managers, medical records and informatics personnel, health economist and medical secretaries.

The health sector in Malawi has experienced a chronic shortage of health care workforce. The shortage of human resources for health is mainly due to low numbers of people being trained, very higher attrition rates of existing staff migrating to the private sector and overseas as well as loss of skilled health workers to HIV and AIDS. In an attempt to reduce the shortage of health workers, Malawi has experimented with various approaches aimed to directly or indirectly increase the number of skilled health workers, including the EHRP (Malawi Government, 2011; MHWO, 2010). The benefits of such approaches have not yet trickled



down to most health facilities, such that health worker shortage still exists in many health facilities including those contracted out to provide SLA services.

Considering that the SLA policy was implemented in an environment where human resource shortage was already present, and that human resource numbers have not kept pace with the SLA policy, it is not surprising that human resources shortage has resurfaced as one of the challenges impeding successful implementation of SLAs in some areas.

#### ***8.2.3.3 Infrastructure***

The UNHABITAT (2011) has argued that there is no iron clad definition of infrastructure, but that infrastructure is most commonly discussed in terms of characteristics. Based on health care provision practices, in this thesis, infrastructure is characterised as the basic facilities, services, and installations needed for the functioning of a health care facility. In the context of CHAM facilities, infrastructure implies the buildings (wards, theatre, laboratory x-ray room etc), electrical and water installations required to provide quality health care service to the public. In this case, infrastructure is the base that enables the various functions necessary in the process of providing health care. When infrastructure is present as defined here, the system can carry out core functions with uniform effectiveness, however, when the infrastructure is weak or deficient, care is compromised.

Some of the facilities that have signed SLA agreements have no proper infrastructure to carry out what is required by an SLA, however, due to political influence and perverse incentives such facilities have been contracted out to provide SLA services. Most informants, reports and evaluative studies have claimed lack of proper essential items that make up a functional infrastructure including, basic medical equipment, improper functioning equipment, poor and absent equipment repair, lack of complementary utilities such as running water, electricity and electricity backups and fridges for vaccines . Given these problems, the quality of services in general can be no better than the infrastructure. However, this has implications for utilisation of services at these facilities, implying that without newly strengthened infrastructure, SLAs cannot be sustained.

#### ***8.2.3.4 Drugs and medical supplies***

The procurement and management of essential drugs and medical supplies is an area which has some influence on the operations of SLA. The current arrangement is that the central

medical stores (CMS) manage drug procurement, by buying in bulk on behalf of the government and reselling some of the drugs to private health care providers, including CHAM facilities, at recovery cost. The advantages of such a centralized procurement are that it allows large orders and international tendering, and potentially provides lower prices and some central organization to establish quality control mechanisms. However, the erratic procurement and supply of drug and medical supplies through CMS, has resulted in untimely supply and stock outs.

The introduction of SLA services was followed by a marked increase in the utilisation of health care services by all concerned population groups. The heightened demand and erratic supply by CMS meant however, that facilities run out of essential drugs and medical supplies, affecting provision of SLA services in most CHAM facilities. Similarly, due to this erratic supply by CMS, some CHAM facilities resorted to buying essential drugs from private providers who charge four to five times what the Central Medical Store would charge.

While some CHAM facilities successfully passed on the price increase to government, others failed to convince the government to accept the high prices they paid. The facilities that were not able to claim from government based on the high prices ended up covering the financial gap on their own after the government insisted to follow CHAM price list based on CMS charges.

#### ***8.2.3.5 Financial resources***

In this discussion, financial resources are defined as money available for spending in the form of cash, liquid security and credit lines. Examining financial resources consists, first of all, of understanding all funding sources and resources allocated to SLA, along the lines of National Health accounts. However, this involves answering two questions: How government agencies responsible for carrying out these 2 functions obtain the resources they require? Similarly this question can be viewed from a different perspective, i.e. how do government agencies who hold financial resources allocate them to those who carry out the provision function. The manner in which government fund holders allocate financial resources to providers is, therefore, the cornerstone of this issue. The second issue has to do with the actual performance. In other words, how the providers, using the financial resource at their disposal

i.e. the funds allocated in the sense given above, effectively organise their production process?

The health sector in Malawi is financed through general taxation and donor support; there are concerns about instability owing to the small tax base, lack of effective taxation mechanisms and unpredictability of international aid. The foregoing suggests that despite the source and instability of financial resources, who controls the allocation of financial resources and the channels that these resources go through determine the responsiveness of SLA to health sector needs.

While there are concerns that those who holds funds and organise the production process may behave opportunistically, it is important to recognise that the emergency of SLA in the health system compounded by greater demand for healthcare services offered implied greater need for more financial resources in the health sector. This considerable increase in the need for financial resources is problematic and increasingly health care managers are searching for ways to address this problem. An analysis of data from informants and various reports suggests that, in general, the Malawi government has inadequate financial resources to fully implement the SLAs. The deficiency of financial resources is demonstrated through various phenomena including delayed payments and inadequate infrastructure as well as skilled human resource shortages as illustrated in the previous subsections.

The inadequacy of financial resources as illustrated above is also related to financial sustainability or the extent to which national expenditures are funded from domestic resources or provide long term stability based on a mix of funding sources (McPake and Kutzin, 1997). The analysis of SLA financial sustainability indicates that the current financial arrangements do not fully support, and would not guarantee the continuity of funding of this policy intervention in the absence of development partners.

#### **8.2.4 Monitoring and evaluation of SLA contracts**

Given that government agencies (principal) and CHAM facilities (agents) have different interests and information asymmetry, monitoring and evaluation is inevitable in this seeming principal agent relation, as the principal has to motivate and ensure that the agent acts in the best interest of the principal rather than in his own interests. Different mechanisms are utilised including monitoring and evaluation, to align the interests of the agent with those of

the principal. In this regard, monitoring and evaluation is considered as a continuous and repetitive process of ensuring that the agent continues to act in the principal's interest.

In terms of SLA, this entails regularly observing, checking and keeping track of specific aspects of the contractual agreement and assessing whether both parties are fulfilling their part in order to achieve the intended purpose. However, monitoring and evaluation is demanding and requires skilled staff, enforcement power and information on the organization to be monitored and evaluated. In addition, monitoring requires a supportive external environment of public sector institutional rules, laws and policies. The results of this thesis indicate that these requirements were not met in Malawi.

The capacity of the MoH to effectively monitor and evaluate SLA is questionable given the weak capacity at both national and district levels. There are apparent capacity constraints which limit the extent to which the MoH can monitor and implement SLAs. Given that government agencies may be sufficiently concerned about the possibility of being exploited by CHAM facilities, and have few resources to monitor and evaluate them, some government agencies choose not to enter into the contractual relation at all, when that relation could have been in the best interests of both CHAM facilities and government in the absence of monitoring difficulties: a suboptimal conclusion that lowers welfare overall. The reluctance in renewing and signing new SLA contracts by some DHO is in part explained by these concerns, despite the implications of such decisions for the provision of healthcare services.

Similarly, given the weak capacity and incentive to monitor and evaluate SLAs, it is less possible for DHOs and Zone officers to ensure that the quality of services provided under SLA meets the expected standards as outlined in the contract. The recognition that monitoring and evaluation are among the challenges in SLA, leads to proposals that monitoring and evaluation are carried out regularly. One suggestion by both CHAM and DHMT informants is that, there should be someone at the Ministry of Health headquarters specifically assigned to deal with matters related to SLA contracts.

Furthermore, due to the multiple agency nature of SLAs, there are also profound constraints on monitoring and evaluation in the form of social and political resistance (Kadzamira et al, 2004). Monitoring and evaluating public sector activities like SLA is an inherently political activity, and difficult to practice in situations of disparate agents with diverging objectives

and political power interests. For instance, small scale evaluative studies (GIZ, 2011; GTZ, 2009; Kadzamira, 2005) have highlighted some gaps which required the government to address; however, considering that, addressing these gaps might require addressing entrenched structural barriers and motivational factors, the government has delayed to act. In circumstances like these, public sector agents are not in a position to enforce monitoring activities, despite injunctions in policy documents, as doing so might expose government weaknesses. Unsurprisingly, government agencies in cases like these prefer to drop monitoring and evaluating issues from the policy agenda, and concentrate on service provision.

Similarly, Kadzamira et al, 2004, noted that monitoring and regulation are a particular challenge for Malawi in that although the civil service is large, it is inefficient and perforated with “ghost workers”. In addition, the authors have argued that, in general there is a lack of policy guidance from government on how non-state providers like CHAM facilities should operate, and where there is guidance, it is focused on government officials being little motivated by a pro poor agenda.

### **8.3 The role of DPs in SLAs**

The involvement of DPs in the Malawi health sector is through various mechanisms, including direct support to the national budget, contribution to the SWAp basket and DP intervention projects implemented by DP organisations or third party organisations such as NGOs, funded by DPs. Even though DPs have always played a major role in the Malawi economy, the economic slowdown in the early 1980s has led to the involvement of more DPs in Malawi.

Due to the economic slowdown, the World Bank together with International Monetary Fund (IMF) introduced reforms through the structural adjustment program. The World Bank and IMF reform programs favoured more involvement of the private sector and decentralisation of the public sector. These reforms involved all sectors of the economy including the health sector. The main rationale for the health sector reforms was to reduce the financial burden of the public health sector, by facilitating a rapidly expanding role for private healthcare providers, both for profit and non-profit (World Bank, 1987; Sen and Koivusalo, 1998). The reforms therefore provided the mechanisms, allowing private investors to take part in the

health sector. Based on the involvement of DPs in Malawi's health sector as illustrated here, two questions emerge in relation to SLA: Is SLA a donor driven idea? Who wants SLA to work? The discussion in the subsequent subsections is focused on these questions.

### ***8.3.1 Is SLA a donor driven idea?***

Malawi's health sector is still dependent on DPs for financial and technical assistance. However, to conclude that SLA is a donor driven idea, involves establishing the grounds on which this conclusion is based. More specifically, there is need to answer the following questions:

What are the DPs and domestic linkages related to health policy in Malawi, and how have these linkages transformed over time, as well as the roles of DPs and domestic institutions in health policy? In addition there is need to understand how DPs actions affect health policy in Malawi. For instance, do DPs employ conditionality or other coercive measures to influence health policy in Malawi and are they successful in doing so?

There are some indications to suggest that SLA is a donor driven idea, as its roots are from the public private partnership rhetoric that has been advanced through health sector reforms discussed earlier. Zwi and Mills (1995) argue, for instance, that, there appear to be almost universal acceptance by aid agencies active in health of the desirability of establishing some form of purchaser-provider split. DPs interest and 'push' for SLAs suggest they identify a stake in SLAs which might be because they believe they offer a more effective way of reaching poor with services, or ideological perspectives for private sector activity irrespective of evidence of effectiveness.

In addition, most of the funding for SLAs is from the SWAp basket, which most donors contribute to, and the health SWAp has increasingly been thought as owned by donors and not by the government. The health sector SWAp on paper is owned by the government, but actions and activities suggest that it is dominated and controlled by DPs. Instead of empowering and relinquishing individual projects to local people, as expressed by Bowie and Mwase (2011), DPs still control the operations of the SWAp remotely using various mechanisms, including the use of technical experts. The actions however imply that, apart from ensuring the effectiveness of aid money and providing health care to the poor communities, DPs are also interested in visibility, attribution, commercial and political

influence. It can therefore be construed that, SLAs are donor driven and are partly being used as a mechanism to achieve some of DPs objectives/interests.

Furthermore, most SLA evaluation studies have been commissioned by bilateral donor agencies such as GTZ/GIZ, DFID and NORAD (GTZ, 2009; GIZ, 2011; Pearson, 2010; NORAD, 2009). The number of evaluative studies by DPs attests to their extensive involvement in SLAs and their seeming ownership of the idea. It is therefore not surprising that there are few documents related to SLAs published by the Ministry of Health, such that during this study, most documents related to SLA were sourced from DPs and NGOs, in particular, CHAM. Following from the high and continued involvement of DPs in SLA as discussed here, it can be construed that, SLA is a DP idea, and that the government of Malawi implement SLA to fulfil aid requirements. The comments of some MoH and DHMT informants attest to this.

The implications of this seeming DP ownership of the SLA idea is that, some public sector officials are less committed to SLA. This may partly be explained by the reluctance of some government officials in prioritising issues related to SLA, as it is an idea which they themselves do not own. The reluctance of aid recipient government officials to implement ideas (programs) that are seemingly owned and driven by DP is not new, and is documented in development literature (Johnson and Wasty, 1993; Burnside and Dollar, 1997; Helleiner, 2000). What is crucial though, is that such programs in many instances fail to achieve the intended outcomes.

### **8.3.2 Who wants SLAs to work?**

This thesis has illustrated that SLA has disparate stakeholders, whose stated objectives suggest they want to contribute to the effective functioning of SLA. On the contrary, the revealed objectives of some of these stakeholders contradict their stated objectives, implying that, the effectiveness of SLA might be of little concern to them. Establishing who wants SLA to work entails providing evidence on SLA promoting actions by the various stakeholders.

Given that donors have come together under SWAp to finance the health sector in general, shows that the donors support SLA and would like to see them perform effectively and achieve their outcome. Similarly, as demonstrated earlier, DPs interest to ensure that SLA should work was also illustrated by a number of evaluative studies carried out by DPs and their agents (DFID, USAID, NORAD and GIZ).

However, the nature of SLA entails that DPs should work with government. Nevertheless, working with government and its agencies implies that DPs should provide incentives to align the objective of GoM and its agencies so as to prioritise SLA activities. In this case, the reluctance by government to act in ways that would help DPs to achieve their goals, acts as a distraction, forcing DPs to impose penalties. Penalties imposed by DPs on the Malawi government are not primarily intended to harm the health sector, but rather they are used as stick and carrot to re-direct the government into behaviour or actions that will lead to the achievement of DPs' agendas.

Unfortunately, when government does not respond effectively to the stick and carrots, DPs implement measures that affect the whole economy including the health care budget which directly funds SLAs. Given this, it can be construed that DPs would want SLAs to work, but that the constraints imposed by government, cause DPs to impose penalties whose side effects, have negative implications on health care provision under SLA.

Despite that, all the actors were able to penalise and constrain each other using various mechanisms. There are indications that some actors have more influence, and that they can sway the outcome of the policy, even though they may not directly control the budget as a principal. SLA evaluation studies commissioned by bilateral donor agencies such as GTZ/GIZ, DFID and NORAD (GTZ, 2009; GIZ, 2011; Pearson, 2010; NORAD, 2009) suggested that DPs had more influence and were managing the government and CHAM facilities owing to their influence in the national budget, particularly the health sector SWAp, while government was managing CHAM facilities, due to CHAM facilities' dependence on government funding through various mechanisms- including SLA.

From the foregoing, it can be construed that DPs indirectly managed government agencies and CHAM facilities, and steered them towards the implementation of SLA. This suggests that, if SLA will survive in the long-run, DPs would have succeeded in re-directing the



government and its agencies into actions that promote SLAs. On the contrary, if SLAs will fail in the long-run, among other factors could be that, government and its agencies would have imposed serious constraints on DPs, and did not respond effectively to the incentives/disincentive inherent in DP and recipient country relationship.

## **8.4 Limitations of the study**

The study presented within this thesis employs a sound structure, organization and methodology to provide evidence of contracting out through SLAs and its effect on access and utilisation. On the other hand, no research is without limitations. There are some limitations to this study and they primarily fall into three categories: Study framework, data and private providers.

### **8.4.1 Study framework**

The framework contained within the research provided an excellent basis to study principals and agents as considered within this thesis. However there were several areas where limitations may have affected the research. The concerns primarily come from the lack of principal agent model to capture structural barriers (e.g., financial and capacity constraints) embedded in the contracts, which cannot be influenced by incentive structures as assumed by the principal agent framework. In doing so the framework made assumptions that motivational risks were equal to structural barriers.

On reflection, political economy theories (Mayer, 1987; Caporasa, 1992) would have been an ideal framework to complement the principal agent framework, in analysing the contractual relationship discussed in this study. The justification in using political economy theories is that, contractual challenges between government and private sector are not all about incentives, but structural barriers as well, and that addressing these structural barriers may be key, to reducing the challenges facing SLAs. Political economy theories explain how political institutions, the political environment and the economic system influence each other, and the implications of such influences. Mayer (1987) has suggested that, a political economy approach interrogates economic doctrines to disclose their sociological and political premises, and regards economic ideas and behaviour not as framework for analysis, but as beliefs and actions that must themselves be explained. Using political economy theories to

supplement the principal agent framework, might have therefore, shed some light and help analyse the structural barriers inherent in SLA contracts.

#### **8.4.2 Data on development partners**

The limitations inherent in data primarily presented themselves in the omission to collect primary data from DPs operating in Malawi. The absence of primary data in relation to development partners during field work hindered a more in-depth analysis of DPs involvement in the Malawi health sector. Consequently, this may have led to DPs involvement and actions being misconstrued. However, in the absence of evidence from primary data sources, the study benefited from the triangulation approach, which permitted the analysis of in country DP reports and government documents containing information on DPs activities. The large number of reports and documents that were used give some comfort that, while this limitation exists, there are safeguards to prevent it critically undermining them.

#### **8.4.3 Private providers**

Since this study focuses on the contracting out decisions of private non- profit health care providers and the Malawi government, the study's external validity may be limited. Other types of decision making parameters such as, geographical location and organization type may yield different outcomes. However, it is reasonable to expect that these results could be generalizable to contracting out decisions across other health care providers in Malawi and other low income countries with similar attributes.

### **8.5 Conclusion**

The conclusion is in three parts reflecting the three main themes discussed in this chapter. The three sets of conclusions as outlined here are linked in that, the first set provides conclusions on the appropriateness of using principal agent and transaction economics to analyse the contractual relationship. The second set of conclusions is focused on the design and implementation of the contractual relationship and lessons learnt. The third set of conclusions is focused on the interaction of DPs, government and CHAM, through their involvement in SLA, which is the basis of the contractual relationship on which this thesis has concentrated on.

### ***Applying principal agent and transaction economics theories***

- Despite that government, DPs and CHAM claimed to share some stated objective functions, this contrasted with their revealed objective functions which contained a range of arguments: including growing public sector, visibility, attribution, political influence and generating financial resources. The contradictions between stated and revealed objective functions partly explain the challenges faced in implementing SLA.
- Penalties were not strictly adhered to, owing to political and economic considerations embedded in government, DP and CHAM relationships. Stakeholders feared that imposing penalties would impact negatively on their economic and political objectives.
- There is resistance by some DHOs to enter into SLA agreements despite the central level approval of the policy; and preference to concentrate on growing the public service with a view to expanding their influence.

### ***Contract design and implementation***

- SLA contractual agreements between CHAM and government agencies were instituted without rigorous analysis of their implications for renegotiations and financial sustainability
- The implementation and analysis of health care service delivery through SLA has mainly focused on the demand side, in particular user charges, while issues related to resources, capacity, institutions, incentives and behaviour of purchaser and providers have received much less attention.
- There is a pervasive agency relationship involving a monopsony principal (Ministry of health) and a monopoly agent (CHAM facilities). These monopolistic and monopsonistic characteristics of SLA actors help explain some of the implementation challenges.
- SLA relies heavily on the institutional arrangements of already existing programs, for instance, the memorandum of understanding between CHAM and Ministry of Health. The absence of SLA specific institutional structure impacts on their functionality, as the already stretched and scarce skilled health personnel are assigned enforcement, governance and accountability roles, instead of leaving them to concentrate on core healthcare issues.

- The current SLA financial arrangements do not fully support, and would not guarantee the continuity of funding in the absence of development partners who contribute to the SWAp basket.

***DPs, health sector and SLAs***

- DPs are heavily involved in the Malawi health sector through various mechanisms including the health sector SWAp which most DPs contribute to. While on paper the SWAp is owned by the government, documented actions and activities suggest that it is dominated and controlled by DPs.
- There are some indications to suggest that SLA is a donor driven idea, as its roots are from the public private partnership rhetoric that has been advanced through health sector reforms to which most DPs subscribe.

The next chapter will provide the conclusion of the thesis, implications for policy and practice, contribution to knowledge, and an agenda for further research.

## **Chapter 9: Conclusions, policy implications and future research**

### **9.0 Introduction**

This thesis has sought to better understand the relationship between CHAM facilities, government agencies and development partners. Notably, it aimed at assessing how the contractual relationship between CHAM health care providers and the Ministry of Health together with the involvement of DPs have impacted on access to maternal and child health services under SLAs in Malawi. The key findings were summarised at the end of the previous chapter, in section 8.5.

The specific objectives of this thesis were achieved by:

- Understanding CHAM and exploring its responses to SLA payments
- Assessing the effect of SLA on access, equity, quality and efficiency of health care provision at CHAM institutions
- Determining the differences in access, utilisation, quality and efficiency under varying SLA contract settings
- Assessing the levels and patterns of access, utilisation, quality and efficiency
- Assessing the views of key informants on access, utilisation, quality and efficiency under SLA.
- Examining factors that might have impacted on the implementation and performance of SLA.
- Examining the stated and revealed objectives of government, development partners and CHAM with regard to SLA.
- Assessing the stated and revealed objectives of individual actors representing CHAM, government and DPs.
- Exploring and highlighting the incentive structures facing government agencies, DPs and CHAM facilities, and how these impact on SLA.

Despite that there is no specific section describing the quality and efficiency aspect of SLA services. The challenges articulated in this thesis; shortage of skilled personnel; shortage of drugs and equipment; congestion ; poor infrastructure; delays in payments by district health office, they all point to the implication on the quality and efficiency of health care services provided. The challenges implies that, some CHAM facilities did not provide the appropriate

quality health services that met the health needs of women and neonates fairly, and that efficiency was compromised by both parties.

The next section provides conclusions of the thesis. The following section discusses implications for policy and practice of essential issues identified in the thesis. Section three presents the contribution made by this study towards knowledge. The final section suggests further areas of research.

## **9.1 Conclusions of the thesis**

### ***SLA specific***

Overall, an important conclusion of this thesis is that SLA has succeeded in improving access to maternal and child health care as well as providing financial risk protection associated with out of pocket expenditure for giving birth and accessing treatment for children under the age of five. In particular, SLA roll out appears to have successfully increased access in facilities located far away from town centres. However, despite this improvement in access and reduction in financial risk, we observe that some supply side factors are impinging on the progress of SLAs.

SLA has diverse stakeholders. These stakeholders respond to different incentives. Effort to reshape the incentives of all the stakeholders involved in SLAs is the main objective of the SLA policy but comprises considerable trade-offs. The conclusion one can draw from this is that, the failure to achieve intended SLA policy outcomes, is not entirely due to lack of knowledge about the process and outcome among health care managers and decision makers, but rather optimizing agents face incentives and constraints that deviate their behaviour from the intended actions and outcomes.

Conflict between government and CHAM has significantly weakened the design and implementation of SLA. Communication between the DHO and CHAM facilities as well as between DHO and Ministry of Health headquarters has become strained and insufficient dialogue is hindering progress. The conclusion one can draw from this is that inherent conflict (in objective functions) has not been reconciled by the contract and therefore continues, as expressed in these observations.

### ***Contracting out in general***

Contracting out health care provision provides public health care managers with an opportunity to draw on private providers' resources and experiences to improve the efficiency of health care service delivery in turn increasing the welfare of the general population. However, like any other tool, there is need to use it in relevant circumstances and appropriately. The conclusion here is that, the effectiveness and success of contracting out depends on a range of contextual and contract-design factors. The dependence of contracting out on contextual and design factors indicate the importance of ensuring that these factors are effectively aligned within the contract, in order to attain effectiveness and success in the contractual relationship. In this regard, the important elements that need to be taken into account when choosing to contract out the provision of public health services might include: the specific investment required, the political and economic environment and the behavioural uncertainty the contract will be subject to.

Furthermore, the thesis has highlighted the complexity of arrangements through which the public sector works with private sector. An important conclusion in this regard is the need for better monitoring, oversight policies and systems to protect public interests, such as the availability and accessibility of essential health services.

### ***DPs and SLAs***

DPs are heavily involved in the Malawi health sector such that there are some indications to suggest that SLA is a donor driven idea. This implies that DPs want SLAs to operate effectively. The conclusion we can draw from this is that the sustainability of SLAs in the absence of DPs is questionable.

## **9.2 Implications for policy and practice**

The findings in this thesis show a potential for doing harm if SLA interventions in the Malawi health sector are not well designed or implemented. For instance, the design that requires altering demand side factors without considering supply side factors puts pressure on the supply factors leading to low quality and, financial risk exposure of CHAM facilities and government agencies. This implies that SLA should address supply side factors in order to

achieve meaningful benefits from this policy instrument. However, this entails considerable improvement in the capacity; financing and institutional arrangements.

The contractual relationship between government and CHAM is constrained by historically and socially determined institutions and organizations. For SLAs to work better there is need to alter or adapt institutions and organizations that govern them in a desired direction. However, given the environment in which SLAs are implemented, in which high levels of organizational fragmentation are combined with multiple agency relations and plural modes of governance, it may require application of significant resources to negotiate, implement and manage delivery of public health programmes through SLAs.

This study has highlighted that the current SLA financial arrangements do not fully support, and may not guarantee the continuity of SLA in the absence of development partners who contribute to the SWAp basket. Achieving continuity entails that domestic financial resources finance recurrent operational costs beyond development partner's support. However, this implies that government should find alternative sources of funding to ensure the continuity of SLA services.

### **9.3 Contribution to knowledge**

This thesis has contributed to knowledge on the subject of contracting out private health care provision; particularly to faith based private health providers, in several ways. Firstly, the study analysed the difficulties of contracting out in a setting where capacity problems are prevalent, and demonstrated how analysis of the combination of multiple agency relationships in organizations with disparate stated and revealed objectives could be used to understand the difficulties of contracting out and illustrate the extent of such problems.

Secondly, the study analysed the difficulties of contracting out from a mixed method perspective and demonstrated how a combination of quantitative and qualitative methodologies could be used to understand the difficulties of contracting out health care in low income settings and illustrate the extent of such challenges. As was illustrated in the results chapters, the qualitative methodology was adopted for its ability to explore the complexities of the contracting out process, while the quantitative methodology permitted the empirical illustration of the levels and patterns of utilization in the contracted out facilities.



Although the thesis is framed around Malawian experience, its central messages may be relevant to health policy discussions in other low income countries as it contributes to the general understanding of the process underlying contracting out of health care services in settings where the public sector is the main purchaser of the contracted out services. In addition, this thesis might be useful not only in contributing to the academic debate about contracting out health care services and public and private partnerships in health care, but it can also provide insightful suggestions, for instance, on the decision of government agencies to provide a particular services themselves or to contract them out to private provider; - make-or .buy decision, to public sector practitioners, who daily face contracting out operational challenges.

## **9.4 Further research**

The study presented within this thesis expanded our understanding and knowledge of SLA contracts and the implications for access and utilisation of selected health care services. However, further research is suggested in this area as many questions still remain. Additional questions remain regarding explanation on whether SLA was more effective than making an investment in the public sector equal to the cost of SLA. There is therefore, need for further studies that assess the cost- effectiveness of contracting out to private providers like CHAM, compared with using public finances to strengthen public sector health care delivery. These studies should aim at providing information about comparative CHAM and government facility performance in service provision.

The adapted framework for the study included CHAM facilities, government and development partners. While primary data was collected from government agencies and CHAM facilities, primary data from DPs was not collected, but used data from secondary sources. Gathering data from DP organisations and their representatives could have generated useful information. There is therefore scope for further research on the specific roles DPs play in relation to SLA. DPs that would be particularly worth studying are those involved in the health SWAp, and the research should focus on mechanisms they use to shape the incentives of SLA actors.

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## Appendixes

### Appendix 1: Letter of support from The Polytechnic- Faculty of Commerce



#### UNIVERSITY OF MALAWI

PRINCIPAL

Charles Mataya PhD

Our Ref.

Your Ref.

Date: 20<sup>th</sup> March 2009

Please address all correspondence  
to the principal

The Malawi Polytechnic

Private Bag 303

Chichiri

Blantyre 3

MALAWI  
Tel.: (265) 870 411  
Fax: (265) 870 578

Telex: 44613

E-Mail: [Principal@poly.ac.mw](mailto:Principal@poly.ac.mw)

**For the Attention of-Sheila Adamson**

Registry Officer (Quality Enhancement)  
Queen Margaret University, Edinburgh  
Musselburgh  
EH21 6UU

Dear Sheila Adamson,

#### **FIELD WORK SUPPORT FOR ELVIS MPAKATI GAMA**

Mr Elvis Mpakati Gama is a current employee of the University of Malawi- The Malawi Polytechnic, as such; he will have access to all facilities available to all members of staff. Additionally, the college is prepared to provide any extra support that he may need while in Malawi conducting fieldwork for his PhD research.

Mr Gama will also have an office with access to internet, and one of the senior staff in the faculty will be assigned as his mentor.

I hope this is in order, however, if you need more information you can contact me.

Yours Sincerely,

A handwritten signature in blue ink, appearing to read 'Willings Botha'.

Willings Botha  
**Dean Faculty of Commerce**

## Appendix 2: Ethical approval letter from COMREC



### UNIVERSITY OF MALAWI

Acting Principal  
K.M. Maleta MBBS, PhD

Our Ref.:

Your Ref.: P.05/10/946

College of Medicine  
Private Bag 360  
Chichiri  
Blantyre 3  
Malawi  
Telephone: 877 245  
877 291  
Fax: 874 700  
Telex: 43744

5<sup>th</sup> August 2010

Mr. E. Mpakati Gama  
C/O Dr. M. Chirwa  
College of Medicine  
Health Management  
P/Bag 360  
Chichiri  
**Blantyre 3**

Dear Mr Gama,

**RE: P.05/10/946 – Evaluating the implications of Service Level Agreements (SLA) on utilization and access to healthcare services at CHAM Institutions**

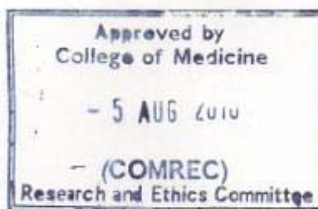
I write to inform you that COMREC reviewed your resubmission of the above mentioned proposal. I am pleased to inform you that your proposal was **approved** after considering that you addressed all the issues which were raised in an earlier review.

As you proceed with the implementation of your study we would like you to take note that all requirements by the college are followed as indicated on the attached page.

Sincerely,

Dr. S. Kamiza

**For: CHAIRMAN - COMREC**



SK/ck

### **Appendix 3: Research information sheet**

#### **RESEARCH INFORMATION SHEET**

##### **Evaluating the implications of service level agreements (SLA) on utilization and access to healthcare services at CHAM institutions**

**Principal Investigator:** Elvis Mpakati Gama

**Co Investigators:** Dr Maureen Chirwa and Professor Barbara McPake

*You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.*

I am a PhD student in Health economics at the Institute for International health and development at Queen Margaret University. As part of this degree I am undertaking a research project leading to a thesis. The research project I am undertaking is examining the implications of service level agreements (SLA) on utilisation and access to healthcare services at CHAM institutions.

In 2002 the Malawi government embarked on an innovative financing mechanism called the Service Level Agreement (SLA) with CHAM institutions. The aims of the SLA's were to enhance access and utilisation of health services by people who otherwise could not get these services due to user fees at CHAM institutions. Since the inception of the SLA in 2002, there have been reports from district health officers and CHAM institutions on their functioning. The reports suggest that the success of SLA in improving access and utilisation of health care services is varied. This implies that the flow of funds from government to CHAM institutions through SLA may not have significantly improved utilisation and access as envisaged. The study aims to evaluate the implications of service level agreements on access and utilisation, and determine factors that might have caused SLA's not to achieve their objectives.

As a participant you will be asked to complete a survey and participate in focus group discussions. It is envisaged that the survey questionnaire will take about a quarter of an hour to complete while the focus group discussion will last for an hour. *It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.*

Responses collected will form the basis of my research project and will be put into a written report (thesis) on an anonymous basis. It will not be possible for you to be identified personally. Only grouped responses will be presented in this report. All material collected will be kept confidential. No other person besides me and my supervisors, Dr Maureen Chirwa and Professor Barbara McPake, will see the completed survey questionnaires and focus group manuscripts.

The thesis will be submitted for marking to the School of Health sciences and deposited in the University Library. It is intended that one or more articles will be submitted for publication in scholarly journals. Questionnaires will be destroyed five years after the end of the research project.

If you have any questions or would like to receive further information about the project, please contact me or my supervisor, Dr Maureen Chirwa, at Health Management Unit, Health Social Science Department, College Of Medicine, and Blantyre

Elvis Mpakati Gama

Signed:

## Appendix 4: Consent form

### Consent Form

#### **Evaluating the implications of service level agreements (SLA) on utilization and access to healthcare services at CHAM institutions**

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: \_\_\_\_\_

Signature of participant: \_\_\_\_\_

Signature of researcher: \_\_\_\_\_

Date: \_\_\_\_\_

Contact details of the researcher

Name of researcher: Elvis Mpakati Gama - Health Economist

Address: University of Malawi  
The Polytechnic  
Private Bag 303, Chichiri, Blantyre 3

Email/ Telephone: [egama@qmu.ac.uk](mailto:egama@qmu.ac.uk) / 0993853785



## Appendix 5: CHAM facility survey questionnaire

### Survey of CHAM institutions and their views on the financial interaction with the public health sector

**Introduction:** The purpose of this survey is to get a better understanding of the financial interaction of the public health sectors and CHAM institutions. The survey is designed for both hospitals and health centres. The survey will touch on the financial issues related to your organisation and any financial interactions with other organisations.

- 1) How would you describe your source of funding for capital investment and recurrent costs?

	Government	Financial institution	International aid	Philanthropy	Others
a) Loan					
b) Grant					
c) Contract					
d) User Fees					
e) Shares					
f) Personal savings					
g) Subsidies					
h) Cash transfers					

- 2) For your most recent major investment (in the last 2 years), what was the source (or what were the sources) of the financing?

*Percent to total investments*

☐ Financed through donors and /or charitable sources

☐ Earnings

☐ Government allocation

☐ Others

Please specify:

- 3) Have you received investment funds from a bank, development finance institution, or NGO in the last two years?

☐ YES

Please specify source, term, interest and collateral

☐ NO

- 4) In case of future investment projects, how do you propose to obtain finance?

☐ International donors

☐ Local donors

- ☐ Bank
- ☐ Government

☐ Other

Please specify

- 5) At what percentage of your full capacity are you now operating? \_\_\_\_\_ percent
- a) Has this increased or decreased in the past three years? Why?
  - b) Have your prices gone up or down in the past year?
  - c) Could you please explain on this trend?

- 6) What percentages of your total services to patients are?

Percent of total revenues

- ☐ Direct out of pocket payments
- ☐ Reimbursed by the health insurance fund
- ☐ Covered through private insurance
- ☐ Financed through donor or charitable sources
- ☐ Services are explicitly free
- ☐ Service level agreement

- 7) For service level agreements, which services do you provide to patients Direct out of pocket payments

- ☐ ANC
- ☐ Delivery
- ☐ TB
- ☐ ART

☐ Others

Please specify

- 8) If you have a service level agreement with government, when was first service level agreement contract signed?

- 9) Are there any services which you provide, for which you are the only provider in the area?

☐ YES

Please specify service(s)

☐ NO

10) A part from the service level agreement, do you have any agreement or contract to provide services for reimbursement by the government?

☐ YES

Please specify service(s)

☐ NO

11) In which specific areas would you suggest that the government provide for private health providers to enable them participate more effectively in public health activities?

**The survey ends here. Thank you very much for your time and help in providing this valuable information.**

If you would be prepared to discuss your responses to this questionnaire, at your convenience, please write your details below.

Name -----

Email Address -----

Telephone number -----

Please use this space if you wish to make any further comments about this questionnaire or the issues raised in it.

## Appendix 6: Health worker's survey questionnaire

### A. Demographic Data:

1.1	Sex	1 = Male	2 = Female
1.2	Marital Status	1 = Single 3 = Divorced 5 = Other	2 = Married 4 = Widowed
1.3	Position/Rank		
1.4	Educational Qualifications		
1.5	Length of Service • in this facility • in career		

### B. Workload and Satisfaction Data:

Are you aware of the Service Level Agreement?

2.1	Yes	No
-----	-----	----

Were you consulted on the policy?

2.2	Yes	No
-----	-----	----

*Please think about your current position and use the scale below to indicate how much you agree or disagree with each statement by indicating the number that best corresponds to your answer*

	Statement	Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
2.1	I think the SLA is a good policy?	1	2	3	4	5
2.2	More people are utilizing services now than before the SLA?	1	2	3	4	5
2.3	My workload has increased after the SLA?	1	2	3	4	5
2.4	The quality of service has decreased with the SLA?	1	2	3	4	5
2.5	I am more likely to consider quitting my job as a result of the SLA	1	2	3	4	5
2.6	I am more satisfied with my work as a result of the SLA	1	2	3	4	5
2.7	In your opinion, what additional changes should be made to the SLA?					

2.8	Is there any further information you would like to add on the SLAs?

**C- Effective implementation / operationalization of SLA is affected by the following factors (*Tick one box from strongly disagree to strongly agree*)**

	Statement	Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
3.1	Delayed cash transfer from Treasury to DHO	1	2	3	4	5
3.2	Prioritization of SLA payment	1	2	3	4	5
3.3	DHMT knowledge of SLA	1	2	3	4	5
3.4	Lack of trust between DHMT and CHAM facilities management	1	2	3	4	5
3.5	Lack of validation system in CHAM's SLA health records	1	2	3	4	5
3.6	In your opinion, what other factors affect SLA operationalization/ implementation?					
3.7	Is there any further information you would like to add on the SLA Implementation system?					

**D- What factor affect quality of SLA health care provided to Maternal and Child health clients?**

	<b>Statement</b>	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Neither disagree or agree</b>	<b>Agree</b>	<b>Strongly agree</b>
4.1	Drug and medical supplies stock out	1	2	3	4	5
4.2	Lack of skilled human resources	1	2	3	4	5
4.3	Poor staff attitudes	1	2	3	4	5
4.4	Lack of appropriate equipment	1	2	3	4	5
4.5	Poor organization and management of Maternal and Child Health services	1	2	3	4	5
4.6	Improper use of MCH data for planning	1	2	3	4	5
4.7	In your opinion, what would you suggest to be changed to improve quality of the services Under SLA?					

**E- The following factors affect utilization of SLA services**

	<b>Statement</b>	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Neither disagree or agree</b>	<b>Agree</b>	<b>Strongly agree</b>
5.1	Community awareness of the existence of SLA	1	2	3	4	5
5.2	Knowledge of available SLA service and benefits	1	2	3	4	5
5.3	Existence of other charges /fees e.g. consultation fees and informal fees	1	2	3	4	5
5.4	Traditional practices regarding maternal and child health care	1	2	3	4	5
5.5	Travel cost to access CHAM facilities	1	2	3	4	5
5.6	Non-medical cost e.g. food and accommodation	1	2	3	4	5
5.7	In your opinion, what additional factors affect SLA service utilization?					

## Appendix 7: Client exit survey –English version

*For all questions please circle the response which is most appropriate, or specify for other*

### 1- Demographics

1.1	Sex	1 = Male	2 = Female
1.2	Marital Status	1 = Single	2 = Married
		3 = Divorced	4 = Widowed
		5 = Other (specify).....	
1.3	Your age (years)	_ _ _	
1.4	How many children do you have who are financially dependent on you?	_ _ _	
1.5	How close to this facility do you live	1 = 0 to 1 km	2 = >1km to <5km
		3 = >5km	
1.6	Travel cost incurred to get here		

### 2- Utilisation and Satisfaction

*Please find below questions about your registration with the Irish Medical Council. Please indicate the most appropriate response or specify for other*

2.1	How often have you used services in the past six months?	1 = once				
		2 = twice				
		3 = three times				
		4 = more than three times				
2.2	Now that services at the facility are free do you use services...?	1 = More often				
		2 = Less often				
		3 = About the same				
2.3	Thinking about the service you received, please circle your satisfaction with <u>each</u> of the following:	Very Dissatisfie d	Dissatisfie d	Neither satisfied nor dissatisfie	Satisfied	Very satisfie

	Quality of Care	1	2	3	4	5
	Free Care	1	2	3	4	5
	Equipment availability	1	2	3	4	5
	Drug availability	1	2	3	4	5
	Staff attitude	1	2	3	4	5
	Waiting Times	1	2	3	4	5

### Cost to access services

3.1	When you visited today were you asked to pay anything for the services? <b>Circle appropriate response</b>	Yes  No  <b>If response is YES go to question 3.4</b>		
3.2	Has not having to pay for health services made a difference to your household budget?	1= Not at all  2= A little  3= A lot		
3.3	Has not having to pay for health services made a difference to the health of your household?	1= Not at all  2= A little  3= A lot		
3.4	Did you pay for any consultation, drugs, laboratory and radiology test <b>Tick appropriate response</b>		Yes	No
	Drugs Laboratory tests Radiology services Consultation fee			
3.5	While visiting were you asked to buy drugs and other medical supplies outside the hospital?	Yes  No		
3.6	While here receiving treatment did any member of staff ask you give them money as away to thank them or do something for you? <b>Circle appropriate response</b>	Yes  No		
3.7	Have you spent any money on food and accommodation during this visit?		Yes	No
	Food Accommodation			

### Prepayment schemes



4.1	Do you have any private health insurance funds to cover visits to doctors or other health care providers where you do not stay overnight?	Yes No
4.2	Do you have any private health insurance funds to cover hospital inpatient care?	Yes No
4.3	In the last 12 months, did you ever not seek health care at outpatient facilities (for example, local doctors, or clinics, or hospital outpatient units) because you could not afford it?	Yes No
4.4	In the last 12 months, did you ever not seek hospital care because you could not afford it?	Yes No

#### Non financial barriers to access

5.1	Did you know that maternal and child health services are provided free of charge at this facility?	Yes No If YES go to 4.2
5.2	how did you know about SLA services Circle appropriate answer	a- through friends b- Health talk at government clinic c- Health talk at CHAM clinic d- Poster at the clinic e- Radio or television f- Others (please specify)  
5.3	Are there other appropriate ways on how people can know about free SLA services? Probe for details	Yes No
5.4	Are there any cultural and traditional practices that you think might have prevented you from utilizing SLA services? Probe for details if yes	Yes No

## Appendix 8: Client exit survey –Chichewa version

### Mafunso a anthu omwe athandizidwa kuchipatala

*Chithandizo chaboma chopelekedwa kuzipatala za mission pofuna kufikala anthu ambili muno m' Malawi*

*Pamafunso onse zungulizani yankho oyenelela*

#### 1- Demographics

1.1	Sex	1 = Mamuna      2= Mkazi
1.2	Ndinu wokwatiwa/ wokwatila	1= Osakwila    2= Okwatila 3= Osiyidwa    4= Ofeledwa 5= Zina (specify).....
1.3	Zaka zanu	_ _ _
1.4	Kodi muli ndi ana angati omwe amadalila chithandizo chandalama kuchokela kwa inu.	_ _ _
1.5	Kumakhala mtunda wautali bwanji kudafika pa malo ano	1 = 0 to 1 km      2 = >1km to <5km 3 = >5km
1.6	Mwayanda bwanji kufinka pamalo ano	1= Ndayenda      2=      3 = Ndabwela pagalimoto Ndakwela njinga 1= Ndayenda      2= Ndakwela njinga
1.7	Kodi munalipila ndalam zingati kudafika pa malo ano?	

#### 2- Utilisation and Satisfaction

*Please find below questions about your registration with the Irish Medical Council. Please indicate the most appropriate response or specify for other*

2.1	Kodi mwalandira chithandizo kangati pa malo ano pa miyezi isanu ndi umodzi yapitayi?	1= Kamodzi 2= Kawili 3 = Katatu 4= Kambili										
2.2	Nanga poti kolandila chithandio pamalo pano ndikwaulera kodi mumagwilitsa ntchito chithandizo chi...	1= Mowilikiza 2 = Mochepeleko 3 = Chimodzimodzi										
2.3	Polingalila chithandizo chimene mwalandila lero, tikuphemphani kuti musakhe malo oyenela maligana ndikakhutitsidwe kanu motere:	<table border="1"> <tr> <td>Osakkutitsidwa kwambili</td> <td>Osakhutitsidwa</td> <td>Pakati kati</td> <td>Mwakhu titsidwa</td> <td>Mwakh titsidwa kwambi i</td> </tr> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> </table>	Osakkutitsidwa kwambili	Osakhutitsidwa	Pakati kati	Mwakhu titsidwa	Mwakh titsidwa kwambi i	1	2	3	4	5
Osakkutitsidwa kwambili	Osakhutitsidwa	Pakati kati	Mwakhu titsidwa	Mwakh titsidwa kwambi i								
1	2	3	4	5								

	Chisamalilo chaulele	1	2	3	4	5
	Kupezeka kwa zipangizo zogwilila ntchito	1	2	3	4	5
	Kupezeka kwa mankhwala	1	2	3	4	5
	Khalidwe la ogwira ntchito	1	2	3	4	5
	Nthawi yodikilila kuti muthandiziwe	1	2	3	4	5

### Cost to access services

3.1	Mutabwela malo ano lero mundfunsidwa kutimupeleke chinachili chonse?	Eya Ayi <b>Ngati yankho lili eva pitani ku funso 3.4</b>			
3.2	Kodi kusalipila pathandizo la zaumoyo kwabeletsa kusitha kulikonse pakagwilitsidwe ntchito kandalama pa banja lanu?	1 = Ngakhale pang'ono 2 = Pang'ono 3 = Kwambili			
3.3	Kodi kusalipila pathandizo la zaumoyo kwabeletsa kusitha kulikonse pa umyo wanu wa pabanja?	1 = Ngakhale pang'ono  2 = Pang'ono 3 = Kwambili			
3.4	Kodi mwalipila ndalama kofunsila chithandizo, mankhwala, kuyzedwa ndi kojambmulidwa mthupi?		<b>Eya</b>	<b>Ayi</b>	<b>Ngati eva, zingati?</b>
		Mankhwala Kuyezedwa Kojembulidwa Kufunsilia chithandizo			
3.5	Mutabwela kodi mwafunsidwa kuti mukagule mankhwala ndi zinthu zina zakuchipatala malo ena?	Eya Ayi Ngati inde, fotokozani...			
3.6	Pamene mumalandila thandizo la mankhwala pamalo ano, kodi alipo mwaogwila ntchito amene anapempha kuti muwapatse ndalama kapena chilichonse kuti alandile thandzio mwansanga	Eya Ayi			
3.7	Mwagwilitsako ntchito ndalama iliyonse pogula chakudya ndi kulipila malo okhala nthawi yolandila chithandizo mmene munabwela?	Chakudya Pogona		Eya	Ayi
					<b>Ngati eva, zingati?</b>

## Prepayment schemes

4.1	Amakulipililani ndi ndani kuchipatala?	Inpatient Outpatient	Eya	Ayi
4.2		Eya  Ayi		
4.3	Pamiyezi khumi ndi iwili yapitayi siminafunsileko thandizo kumalo ena opeleka thandizo la zaumoyo mongoyendela? Chifukwa simunakakwanitsa?	Eya  Ayi Ngati eya, chifukwa chani .....		
4.4		Eya Ayi		

## Non financial barriers to access

5.1	Kodi mumadziwa kuti chithandizo chauchembekelele wa amayi ndi chithandizo cha ana ndi zaulele pa chipatala pano?	Eya Ayi
5.2	Kodi munadziwa bwanji zamgwilizano wa undina wa za unmoyo ndi zipatala za mission. Zungulizani yankho loyenelela.	kudzela mwa anzanu  Maphunzilo azaumoyo muzipatala za boma  g- Maphunzilo azaumoyo muzipatala za mission  Zithunzi zoyika pakhoma za kuchapatala  Wayilesi kapena wayilesi ya kanema  Zina (tchulani) _____ _____
5.3	Kodi pali njira zina zoyenerera zomwe anthu angadziwire za mgwirizano umenewu?	Eya Ayi
5.4	Kodi pali miyambo ndi zikhulupiliro zina zimene zingakulaphereseni kupeza zithandizo kudzereka mu mgwirizano umenewu? Fufuzani ngati avomera.	Eya Ayi

## **Appendix 9: DHMT focus group discussion schedule – English version**

1. Do you have formalized relationships with CHAM health care providers and other health care programs in your district? Please describe.
2. What specific efforts have you made to work with CHAM health care providers or other health care programs? For instance, have you surveyed CHAM hospitals regarding the Service level agreement program? If so, what was the outcome?
3. Which aspects of your program elicit effective contact with CHAM institutions and other health care programs?
4. What communication methods have you used with private health care providers and other health care programs? For instance, do you conduct private health care provider's advisory meetings or send out letters or newsletters?
5. Does your office align with organizations, collaboratives or other sources that allow you access to private health care providers and other health care programs?
6. Does your office employ, contract or consult with professionals from other health care programs?
7. As a result of your efforts with CHAM health care providers and other health care programs, how have your program and participants benefited?
8. What are your main considerations in deciding to contract out to CHAM institutions rather than using public providers?
9. Is there a shared vision, which is accepted by CHAM health care providers?
10. Is the service level agreement contract consistent with your organization's structure, articles of cooperation and/or legislative mandates?
11. Is the service level agreement contract consistent with the health care products and services?
12. Does the service level agreement contract reflect the community's understanding of the government mission?
13. How does the service level agreement contract benefit the government?
14. Has there been any negative impact of service level agreement on your programs? For instance, were there increased costs related to SLA contracts, such as, providing training or training materials, accommodating increased referrals or requests for special nutritional products, etc?
15. What are the operational barriers in implementing the service level agreement contracts?
16. What will enhance the implementing of the service level agreements? Do the enhancers outweigh the barriers?
17. How are service level agreements evaluated? Can the outcomes be monitored and measured? How often?
18. What are the expected outcomes?
19. What recommendations do you have for working with private health care providers and other health care programs in the current health care environment?

## **Appendix 10: DHMT focus group discussion schedule - Chichewa version**

### **ZOKAMBIRANA PA MAGULU NDI AKULUAKULU A ZAUMOYO PA BOMA**

1. Kodi muli pa ubale wa mtundu uliwonse ndi zipatala zomwe sizaboma m'dela lanulo kapena magulu a zaumoyo alionse m'boma lanu? Ngati ndi choncho tatiuzani.
2. Munatsata njira zotani kuti muyambe kugwirira ntchito limodzi ndi azipatala zomwe zizaboma?
3. Pamgwirizano umenewu ndi mbali iti imene mwathandizika ndi azaumoyo amenewa?
4. Mumafalitsa uthenga wanu potsata njira zANJI pa mgwirizano wanu? Mwachitsanzo, kuchita misonkhano ya uphungu kapena kutumiza makalata?
5. Pa ntchito yanu muli pa mgwirizano ndi mabungwe enanso, kapena kugwira nawo limodzi nteito zaumoyo?
6. Pa ntchito panu munalembe wa zaumoyo, kapena obwera kupereka uphungu wa zaumoyo?
7. Anthu omwe amatsatira mgwirizano wanu ndi zipatala zomwe zizaboma apindula bwanji?
8. Nanga inuyo phindu lanu ndi lotani pa mgwirizano wanu ndi zipatala zomwe sizabomazi?
9. Ndi ubwino wANJI womwe mumapeza kuchokera kumngwirizano umenewo kumbali ya zipatala zomwe sizabomazi?
10. Ndondomeko ya mgwirizano wanu ndi zolingana ndi kayendetsedwe ndi zolinga za pa ntchito panu?
11. Kodi mgwirizano wanu ndi wolingana ndi kayendetsedwe ka ntchito za umoyo?
12. Kodi mgwirizano wanu ukupindulira anthu molingana ndi mfundo za boma?
13. Boma lipindula bwanji ndi mgwirizano umenewu?
14. Ndi mabvuto otani omwe mwakumana nawo pa mgwirizano wanu? Monga kukwera kwa mitengo, chifukwa cha maphunziro, katundu ophunzilira, kapena chifukwa za nthandizo la zakudya zopatsa thanzi?
15. Pokhazikitsa mgwirizano umenewu panali mabvuto anji?
16. Ndi nfundo zANJI zomwe mupititsire patsogolo mgwirizananu? Nanga nfundozi zithandiza bwanji pa mabvuto omwe alipo?
17. Mgwirizano wu mumaunikira momwe ukuyendera? Nanga zotsatira zimaunikiridwa kuti mupeze ngati zili bwino kapena ai? Nanga izi mwachitapo kangati?
18. Chiyembekezo chanu ndi chotani pa mgwirizananu?
19. Ndemanga zanu ndi zotani pa mgwirizananu?

## **APPENDIX 11: CHAM Focus group discussion Schedule – English version**

1. Please summarize the government's current health sector objectives. (Alternatively, confirm Health sector objectives per latest national health plan.)
2. How does the private sector fit into these objectives at present? How do private and NGO Health service providers and other suppliers contribute to these objectives?
3. Does the government have a formal policy about the role of the private sector in health care Provision? If so, please describe. Informal policy
4. Your institution receives funding from different sources; of these sources which one do you consider to be the main one? And why
5. Do you think the service level agreements have achieved what the government intend them for?
6. Apart from the service level agreements, does the government provide other resources to you institutions?
7. Without the service level agreement and other government funding would you institution still operates?
8. Do you rely on groups outside government to monitor or influence the private sector in health? (Medical associations ,other professional groups, private sector lobbying groups, consumer or Patient organisation or others) If so, how do you interface with these organisations?
9. Do you oversee their activities in any area? Do you support their activities in any area?
10. Do you have any concerns about CHAM's current or future involvement in service Level agreements? Please Specify
- 11 .How do you wish CHAM contribute to meeting government's health sector goals in the Future? How might CHAM constrain achievement of health sector goals?
- 12 If the latter, what measures might be taken to avoid or minimize the impact?
- 13 Government usually rely on external advisers, such as academics or other professionals, but also political groups, for policy advice, including advice on financing faith based organisations. Are there any policy advisers we should meet to continue to explore the opportunities and issues concerning government funding for service level agreements?
15. Any other comments?

## **Appendix 12: CHAM focus group discussion schedule – Chichewa version**

### **ZOKAMBIKANA M'MAGULU PA NKHANI ZA ZIPATALA ZOMWE SIZABOMA**

1. Zolinga za boma pa nkhani zaumoyo ndi zotani?
2. Ndi chinthu chanji chomwe mabungwe omwe siaboma athandizila pa zaumoyo panopa?
3. Pali mgwirizano uliwonse ndi boma pa mbali yakayendetsedwe ka zaumoyo? Ngati ndi chonchi mungatiuzeko
4. Bungwe lanu limalandira thandizo kuchokera ku mabungwe osiyanasiyana, kuthandizo lomwe mumalandira ndi bungwe liti lomwe mumalandira? Ndipo ndi chifukwa chiyani?
5. Mukuganiza kuti pa zomwe munagwirizana zathandiza zaumoyo, zathandiza zolinga za boma?
6. Kupatula pa zomwe munagwirizana zaumoyo kodi boma limapereka chithandizo china chilichonse kwa inu?
7. Kupatula thandizo la boma, kapena mabungwe ena kodi bungwe lanu likanapitilira kuyenda?
8. Mumadalira magulu omwe siaboma kukuyang'anirani kapena kukakamiza mabungwe omwe siaboma pa zaumoyo? (mabunger azaumoyo, ndi ena omwe ntchito yawonso ndi zaumoyo kukopa magulu ena) ngati zili choncho mumakambirana bwanji ndi mabungwe amenewa.
9. Mumayang'anira zomwe zikuchitika m'madera awo ngati ndi choncho mumathandizira zochitikachitika m'madera awo?
10. Muli ndi pempho ndi m'mene (CHAM) azaumoyo omwe siabomawa agwirira ntchito panopa kapena mtsongolo m'mene azizangwirira ntchito?
11. Mukuganiza kuti a zaumoyo omwe siabomawa angathandizire bwanji pa zokambirana ndi boma zokhudzana ndi umoyo mtsogolomu? Nanga inuyo mungakwanitse bwanji zolinga za umoyo.
12. Ngati ndi chomwecho ndi njira zANJI zomwe muzatsate kuti ntchito iwoneke?
13. Boma limadalira alangizi akunja ndi ena andale pouza zomwe lingachite ndi zina zokhudzana ndi chuma? Kodi palibe alangizi ena omwe atha kuthandizira kayendetsedwe ka thandizo lomwe boma limapeza pa zaumoyo mumgwirizano wanu?
14. Mungakhale ndi ndemanga?



**Appendix 13: Health facilities and districts included in the study**

<b>Health facility</b>	<b>District</b>
Trinity Mission hospital	Nsanje
St Joseph Mission Hospital	Chiradzulu
Mulanje Mission Hospital	Mulanje
Holy Family Mission Hospital	Phalombe
Pirimiti Community hospital	Zomba
Nkope health Centre	Mangochi
Mtengo wamthenga hospital	Dowa
Embangweni Mission hospital	Mzimba
Mabiri health Centre	Mzimba

**Appendix 14: Malawi government CHAM memorandum of understanding – 2002**

**MEMORANDUM OF UNDERSTANDING**

**BETWEEN**

**GOVERNMENT OF THE REPUBLIC OF MALAWI**

**AND**

**CHRISTIAN HEALTH ASSOCIATION OF MALAWI (CHAM)**

**DATED**

**DECEMBER, 2002**

**THIS MEMORANDUM OF UNDERSTANDING is made this 9<sup>th</sup> day of December, 2002 between the GOVERNMENT OF THE REPUBLIC OF MALAWI, represented by the Ministry of Finance and the CHRISTIAN HEALTH ASSOCIATION OF MALAWI of Post Office Box 30378, Lilongwe 3. (Thereinafter called "CHAM") of the other part.**

WHEREAS the Government and CHAM-

- (a) are aware that the provision of health services to the community constitutes an essential ingredient for the well-being of the people and that the provision of such services in Malawi contributes to the physical, mental and social development of the people of Malawi;
- (b) are aware that it is Government's primary responsibility to provide health services to the nation and CHAM's role is to complement Government efforts in line with Government policy;
- (c) acknowledge the respective duties of Government and CHAM to provide, promote, foster, improve and expand health services all over Malawi, within the context of national health priorities;
- (d) note that there is room for improvement in the collaboration and co-ordination between the Government and CHAM, in particular in making the Essential Health Package (EHP) available to all Malawians;
- (e) recognize the significant role in the delivery of health services so far played by CHAM; and

- (f) are determined to chart out agreed actions for the Government and CHAM in the development of the health service, with the view to financing, coordination , improving and expanding health services, for the well being of all Malawians, especially the rural poor.

NOW, THEREFORE, the Government and CHAM hereby agree as follows:

## **ARTICLE 1**

### **INTERPRETATION**

Unless the context otherwise requires, the following terms whenever used in this Memorandum of Understanding have the following meanings-

“CHAM” means the Christian Health Association of Malawi;

“CHAM unit” means a CHAM hospital or health centre;

“General Assembly” means the Christian Health Association of Malawi General Assembly;

“Government” means the Government of the Republic of Malawi, and as represented by the Ministry of Health;

“Local Staff” shall mean staff working in CHAM Units according to the staff establishment as approved by Government;

“Associated Member” shall mean a non-governmental, not for profit health unit recognized by the Government of Malawi, which has been

approved by CHAM General Assembly and which is not eligible for the Government subvention to CHAM;

“Party” means the Government of the Republic of Malawi or the Christian Health Association of Malawi; as the case may be.

## **ARTICLE 2**

### **CHRISTIAN HEALTH ASSOCIATION OF MALAWI GENERAL ASSEMBLY**

1. CHAM shall have a governing body to be known as CHRISTIAN HEALTH ASSOCIATION OF MALAWI GENERAL ASSEMBLY (hereinafter called the “General Assembly)
2. The primary function of the General Assembly shall be –
  - (a) to advise on policies in all matters related to health services provided by CHAM Units, within the context of national health priorities;
  - (b) to monitor programmes for the provision, implementation, rehabilitation and expansion and expansion of services in CHAM units; and
  - (c) to oversee the administration of finances (borrowed, granted, generated or allocated) for the purposes of the provision, improvement, rehabilitation and expansion of health services by CHAM

## **ARTICLE 3**

### **MEMBERSHIP OF THE GENERAL ASSEMBLY**

1. Membership of the General Assembly shall comprise the Malawi

Council of Churches, the Episcopal Conference of Malawi and Associate Members.

2. The Secretary to the Treasury and the Secretary for Health and Population or their representatives shall represent the Government in General Assembly meetings.
3. Each member shall have one vote.

#### **ARTICLE 4**

##### **CHAM SECRETARIAT**

1. CHAM shall have a Secretariat
2. The Secretariat shall be subordinate to the General Assembly and shall report to the General Assembly through the Board of Directors;
3. The Secretariat shall be responsible to the General Assembly in all matters related to this Agreement and activities for which the Secretariat was established.

#### **ARTICLE 5**

##### **HEALTH BOARD OF GOVERNORS AND HEALTH CENTRE ADVISORY COMMITTEES**

1. Each CHAM hospital and health centre shall have a governing body to be known as "Health Board of Governors" and Health Centre Advisory Committee" respectively for the purpose of overseeing the management of the hospital/health centre.
2. Membership of the "Health Board of Governors" and the Health

Centre Advisory Committee shall include representatives from the District Health Office, two members of the District Assembly in whose area the facility lies, a member from the community in which the CHAM unit is situated, the CHAM Secretariat, and the owners of the CHAM unit.

## **ARTICLE 6**

### **COLLABORATION AND COORDINATION BETWEEN THE GOVERNMENTS AND CHAM**

1. The staff establishment for each CHAM unit shall be as agreed between the Government of Malawi through the MOH and CHAM.
2. The Government shall determine in liason with CHAM secretariat facilities to be introduced ob CHAM pay roll based on both need and inability of Government to offer services being supplies by the CHAM facility
3. The Government shall not be responsible for CHAM PE to staff employed by a CHAM facility which is within three kilometer radius.
4. CHAM units shall endeavour to supply services to the communities within their catchment population, however defined, in such a manner as will be deemed efficient by the purchasers of the services.
5. Where the Government establishes that it is no longer efficient to offer services to through a CHAM unit, the Government, acting in the interest of and in collaboration with the community being served by the CHAM facility, shall determine available options for delivering services to the community, including but not limited to contracting another provider and constructing an alternative facility within a reasonable distance such as would be to the advantage of the community

6. Where a the Government as made a resolution in 5 above, the payment of PE to the facility by Government shall be terminated
2. The actual payroll as derived from staffing levels agreed under paragraph1 of this Article shall be the basis, under paragraph 4 of Article 7 for Government funding to CHAM Units for personnel emoluments of local staff.
3. CHAM units shall employ persons who are competent and hold requisite qualifications as recognized by the government and should be registered by the relevant regulatory bodies.
4. There shall be established a mechanism for consultation and liaison between Government and CHAM aimed at rationalizing staffing levels.
5. Service agreement shall be established wherever possible as a mechanism for maximizing efficiency in the management of health services and maximizing access of the population at large to health services, particularly those included in the Essential Health Package (EHP).

## **ARTICLE 7**

### **OBLIGATIONS OF GOVERNMENT AND CHAM**

1. The Government shall not take over a CHAM unit unless by mutual agreement and unless it is in the interest of the population being served by that unit.



2. The Government shall respect the ethics of the owners of the CHAM Units.
3. CHAM shall ensure that the conditions for services applicable to local personnel of CHAM units are in line with those applicable to Government personnel.
4. The Government shall provide financial assistance to CHAM Units, with respect to salaries, housing allowances, leave grants, pension scheme contributions for local staff and any other allowances applicable in the Civil Service and as introduced by Government from time to time.
5. The Government shall, in addition to paragraph 4, provide financial assistance in cases where service agreements are in operation, as described under paragraph 5 of article 6. Where CHAM units are not covered by a service agreement with Government, CHAM units shall ensure a formal exemption policy for user fee charges is in place and publicity disseminated.
6. CHAM shall seek approval for sitting up of a new health facility or upgrading a health facility from Government. CHAM shall consult with Government on major rehabilitation or extension of facilities.

## **ARTICLE 8**

### **FINANCIAL ACCOUNTABILITY BY CHAM UNITS**

1. Every year CHAM shall submit to Government its personnel emoluments budget in the format and manner the Government will prescribe and once the budget has been agreed and approved by

Parliament, CHAM shall not act in a manner as to require revision of the budget without approval from the Government

2. CHAM shall submit monthly expenditure returns within 10 days after the end of the month or as may be prescribed by Government from time to time and subsequent funding will depend upon receipt of the monthly expenditure returns.
3. Funding for personnel emoluments will depend on receipt of evidence of PAYE deductions to the Malawi revenue Authority (MRA)
4. The Government's assistance under this Memorandum of Understanding shall be channeled through CHAM Secretariat and shall be given at monthly intervals.
5. CHAM Units, through CHAM Secretariat, shall every three months prepare and deliver to the Ministry of Health -
  - a. certified payroll with a schedule for filled posts;
  - b. an up-date staff return;
  - c. financial statements for funds other than PE from Government to CHAM.
6. CHAM shall declare the savings from the Government subvention from any CHAM Unit to the Government every month in which the subvention has been made.
7. The Government shall have the right to audit the books of Accounts of CHAM Secretariat and CHAM Units and CHAM shall furnish information as is required by Government for purposes of accounting for Government funds given to CHAM.

8. In the spirit of the Sector Wide Approach (SWAp) – a policy the Government is pursuing, CHAM will disclose in a disaggregated format all sources of external and internal funding received or generated and all expenditures undertaken that pertain to the health sector.

## **ARTICLE 9**

### **ASSIGNMENT**

Neither Party shall assign this Memorandum of Understanding nor any part thereof to any part unless prior consent of the party is given in writing

## **ARTICLE 10**

### **GOOD FAITH AND FAIRNESS**

1. The parties undertake to act in good faith with respect to each other's rights and obligations under this Memorandum of Understanding and to adopt all reasonable measures to ensure the realization of the objective of this Memorandum of Understanding.
3. The Parties recognize that it is impractical in this Memorandum of Understanding to provide for every contingency which may arise during the life of this Memorandum of Understanding and the parties hereby state that it is their intention that this Memorandum of Understanding should operate fairly between them and that if during the term of this Memorandum of Understanding either Party believes that the Memorandum is operating unfairly, the Parties shall

use their best efforts to agree on such action as may be necessary to remove the cause or causes of such unfairness but failure to agree on any action pursuant to this Article shall give rise to a dispute subject to arbitration in accordance with Article 11 thereof.

## **ARTICLE 11**

### **SETTLEMENT OF DISPUTES**

1. The Parties shall use their best efforts to settle amicably all disputes arising out of or connection with this Memorandum of Understanding or the interpretation thereof.
2. Any dispute between the Parties on matters arising pursuant to this Memorandum of Understanding which cannot be settled amicably within thirty (30) days after receipt by one Party of the other Party's request for such amicable settlement may be submitted by either Party to arbitration in accordance with the provisions of the Arbitration Act (Cap.6.03 of the Laws of Malawi).

## **ARTICLE 12**

### **AMENDMENT**

1. Any amendment to this Memorandum of Understanding may be Negotiated between the Parties.
2. Any amendment agreed by the Parties shall be embodied in a written document signed by both parties.

## **ARTICLE 13**

## **TERMINATION**

A Party wishing to terminate this Memorandum of Understanding shall give the other Party three (3) months notice in writing.

## **ARTICLE 14**

### **NOTICES**

Any notice, request or any other communication required or permitted to be given or made pursuant to this Memorandum of Understanding shall be in writing and addressed as follows-

For the Government

The Secretary for Health  
Ministry of Health  
P.O. Box 30377, Lilongwe 3.  
Fax No. 01 789 431

For CHAM

The Executive Director  
CHAM  
P.O. Box 30378, Lilongwe 3  
Fax no. 01775 406/01 776 492  
Email: chamsec@malawi .net

IN WITNESS WHEREOF the Parties hereto have by their respective duly authorized representatives signed this Memorandum of Understanding on the day and year first above written.

1. For and on behalf of the Government

Ministry of Finance

Signature: \_\_\_\_\_

Full Names: -----  
Designation: -----  
Date -----

Ministry of Health

Signature: -----  
Full Names: -----  
Designation: -----  
Date: -----

In the presence of-

Ministry of Justice -----  
Signature: -----  
Full Names: -----  
Designation: -----  
Dates: -----

2. For and on behalf of CHAM

Signature: -----  
Full Names: -----  
Designation: -----  
Date: -----

In the presence of-

Signature: -----  
Full Names: -----  
Designation: -----  
Date: -----

**DRAFT**

**MEMORANDUM OF UNDERSTANDING**

**BETWEEN**

**GOVERNMENT OF THE REPUBLIC OF MALAWI**

**AND**

**CHRISTIAN HEALTH ASSOCIATION OF MALAWI  
(CHAM)**

**2009**

This MEMORANDUM OF UNDERSTANDING (hereinafter called "MOU") is made and entered into effect on this ..... day of ....., 2009 between the GOVERNMENT OF THE REPUBLIC OF MALAWI, and the CHRISTIAN HEALTH ASSOCIATION OF MALAWI (hereinafter called "CHAM") with principal office at Post Office Box 30378, Lilongwe 3. The MOU will be valid for a period of five years and supersedes the earlier MOU of December 2002.

## **PREAMBLE**

1. The Malawi Government is committed to offering free essential health services to all residents in Malawi.
2. Most CHAM facilities are located in communities where the Government currently does not have a health facility. CHAM facilities charge user fees to their clients many of whom are very poor and face considerable financial difficulties. User-fees enhance financial barriers to health care utilization and create avoidable inequalities in health care hence threatening the achievement of the health sector's objectives of universal coverage of essential health services.

Both parties therefore

3. Understand that it is not in their interest for certain sections of Malawi society to be paying for health services whereas other sections enjoy free Government services for reasons other than choice.
4. Commit themselves to improving and expanding access to quality health services to all Malawians in a sustainable and cost-effective manner for the well being of all Malawians, especially the poor and vulnerable communities
5. Commit themselves to reducing unjustified inequalities in access to health care due to user fees at CHAM facilities.

NOW, THEREFORE, the Government and CHAM hereby agree as follows:

## **ARTICLE 1**

### **INTERPRETATION**

Unless the context otherwise requires, the following terms whenever used in this Memorandum of Understanding have the following meanings-

**CHAM** means the Christian Health Association of Malawi;

**Local Assembly** refers to a District Assembly or A City Assembly

**Government** means the Government of the Republic of Malawi, and as represented by the Ministry of Health or Ministry of Local Government or Local Assemblies



**Purchaser** refers to a Local Assembly or Ministry of Health that makes payments to a CHAM facility on behalf of service users.

**Provider** refers to a CHAM facility offering services to population within its catchment area.

**Party** means the Government of the Republic of Malawi or the Christian Health Association of Malawi as the case may be.

**Service Level Agreement** shall refer to any contract between a purchaser and a CHAM provider that aims at increasing access to health care by reducing or eliminating the user fees paid by consumers of health care at CHAM facilities.

**Capitation** A fixed amount of money for providing services to a patient for a particular period of time, including costs associated with referrals to hospitals or specialists, as well as ordering tests.

## ARTICLE 2

### THE NATURE OF THE AGREEMENT

This Memorandum of Understanding is an agreement between the Malawi Government and CHAM. The overall objective of this agreement is to increase access to health service use by clients around CHAM facilities through the removal of user fees. This will be achieved through implementation of Service Level Agreements (SLAs) between the Government and CHAM which will make it possible for CHAM health facilities to offer some or the entire range of the essential health services for free to individuals within their catchment areas.

The following shall therefore be the specific objectives of the SLAs

3. *To expand coverage of essential health services in a cost-effective and equitable manner*
4. *To improve the quality of health services to populations within the catchment areas of CHAM facilities.*

## ARTICLE 3

### GUIDELINES FOR ESTABLISHMENT AND MANAGEMENT OF SLAs

The following shall be the procedures to be followed by district assemblies in establishing and implementing SLAs.

1. The Health Committee of the Local Assembly shall conduct a situation analysis of health service coverage in the district and determine areas without a public health facility. The analysis shall inform areas requiring facility based

public provision of health services. This shall document all areas that are covered by CHAM and determine whether a SLA is appropriate or not.

2. A CHAM facility shall be considered for SLA if it is confirmed that the following pre-conditions have been met; (1) The distance to the nearest facility is at least 7 Km in the cases of health centres, and at least 20 Km in the case of hospitals, (2) The facility has a catchment population of at least 7,000 in the case of health centre, and 25,000 in the case of hospital (3) The facility staff based on the minimum requirements of the MOH of 2 medical assistants and 2 nurses for a health centre, (4) the facility has running water inside the building, electricity and telecommunication facilities.
3. Once the above considerations are met, the purchaser shall initiate discussions with the relevant stakeholders such as facility proprietors and managers, Zonal Health Service Offices (ZHSO), Ministry of Health (MOH), and CHAM Secretariat on the feasibility of the SLA, including an assessment and documentation of the costs and benefits of the proposed SLA, as well as the capacity of the provider (i.e. human resources, infrastructure, equipment and drugs) to implement the SLA. This shall include an assessment of facility managements' concern on the health of the catchment population. In addition, it must also be established that the facility management is genuinely or partially concerned with the welfare of its clients and that the possible SLA is more likely to achieve the objective of increased access to quality health services as well as undertake activities to reduce or contain costs
4. At the facility level, the Health Sub-Committee of the Area Development Committee shall oversee the establishment, management and monitoring of the SLA. This committee shall report to the Area Development Committee which in turn, shall report to the Health Committee of the Local Assembly. To the extent possible, all critical issues likely to impact negatively on the implementation of the SLA shall be resolved before the commencement of SLA.
5. A SLA between the facility proprietors and the Local Assembly shall be signed before implementing any SLA. This shall outline service gaps in the target areas, options for improving service coverage, justifications for the SLA over other options, the villages to be targeted, estimated number of beneficiaries, the outputs to be delivered and justification for the payment mechanism, administrative structures for implementation and monitoring of the SLA including names of Health Sub-Committee of the area development committee, strategies for maintaining or improving quality of care, performance monitoring indicators including indicators for quality and outputs, strategies for containing costs, and systems and structures for monitoring and evaluating the performance the SLA. Copies of the draft SLA shall be sent to the Zonal Health Office and Department of Planning and Policy Development for review and technical input before it is signed. A

sample SLA between a Local Assembly and a CHAM facility is attached as appendix 1 for reference.

6. Once the terms of the contract is agreed, the SLA shall be signed before implementation. No SLA shall be effected before it has been agreed and duly signed by the relevant stakeholders. Signatories to the SLA shall be the Chairperson of the Area Development Committee, the Chief Executive/ District Commissioner and the Provider. The MOH and CHAM Secretariat shall sign as witnesses.
7. Once the SLA has been signed, copies shall be sent to the Zonal Support Office, the Department of Planning and Policy Development in the MOH and Department of Planning at CHAM Secretariat.
8. At the national level, the Public Private Partnership Technical Working Group (PPP TWG) shall oversee implementation of SLAs in the country. The PPP TWG shall advise Senior management of MOH and CHAM on policy matters related to SLAs
9. The Department of Planning and Policy Development of the Ministry of Health and the Department of Planning at CHAM secretariat shall each have dedicated staff responsible for planning, monitoring and evaluation of SLAs. It shall be responsible, among other things, for developing and updating the price list jointly with CHAM Secretariat. The two Departments shall be represented in the PPP TWG

#### **ARTICLE 4**

##### **Payment mechanism for providers**

All SLAs shall be performance based. Purchasers and providers shall agree explicitly, before implementation, on the output to be delivered. Providers shall be reimbursed for delivery of outputs based on a capitation payment system. Under this reimbursement system providers shall have two alternatives.

The first option shall be to specify and quantify services to be provided and agree with provider on the price to be paid for each service. Under this payment mechanism, the quantity of services to be demanded over contract period shall be known by the purchaser and the provider's role shall be to supply health care in a manner that satisfies the demand. Since the prices for conditions shall have been specified by the Ministry and CHAM Secretariat, the purchasers shall simply transfer the estimated total amount of money, before the service is offered, to the provider at intervals that align best to its cash flow and make it easy for the provider to offer the service. This system shall be recommended where purchasers have great trust that the provider will act in the purchaser's best. Before making the next payment, purchasers shall verify that the agreed services have been delivered as agreed in the SLA.

The Second option shall be to specify the population that will be targeted by the SLA, adjust for factors likely to predict use of health care, and allocate an amount of money to each expected user. As in the first option, the purchaser shall simply transfer to total estimated amount of money to the provider at specified intervals. Capitation shall be implemented by purchasers primarily concerned with maximising the number of beneficiaries and containing costs. Because this payment system has scope for comprised quantity as well as quality, purchaser shall put in place a strong system for monitoring and verifying that users actually accessed the service and that the services rendered were of the right quantity and quality.

## **ARTICLE 5**

### **MONITORING AND EVALUATION**

1. The Department of Planning and Policy Development in the Ministry of Health, and the Department of Planning at CHAM Secretariat shall jointly be responsible for designing performance based monitoring and evaluation tool for assessing progress in the implementation of SLA in the country. This shall be made available to all Local Assemblies. Local Assemblies shall adapt this tool with guidance from the two departments.
2. The MOH and CHAM Secretariat shall undertake joint quarterly SLA monitoring and evaluation visits every year. This shall be done with Assistance from the Zonal Support Offices of the MOH and CHAM Health Coordinators. Each facility participating in the SLA shall be visited at least once a year jointly by the MOH, CHAM and Local Assemblies. The findings and recommendations of the monitoring and evaluation visits shall be sent to the Local Assembly for action.
3. The Local Assemblies shall undertake monthly supervision visits using the Supervision checklist and shall compile and send to the Zone and MOH quarterly supervision reports.
4. The Health Committee of the Local Assembly shall meet at least bi-annually to discuss issues arising from the monitoring and evaluation reports as well as other issues related to implementation of SLA
5. CHAM facilities with SLAs shall send monthly activity reports to the Local Assembly detailing progress and challenges in the delivery of contracted outputs
6. The MOH and CHAM shall also commission independent research to consistently update on the cost-effectiveness of SLAs as a strategy for meeting the objectives of this MOU. A SLA bulletin shall be published and disseminated widely to all stakeholders through an annual SLA conference, each year by the MOH through a joint process with CHAM Secretariat.

## **ARTICLE 6**

### **OBLIGATIONS OF GOVERNMENT AND CHAM**

7. CHAM shall offer services to its clients in an efficient manner.
8. The Government shall reimburse all legitimate costs associated with SLAs in a timely manner. No transfer from Government shall be made to CHAM outside this agreement
9. The Government shall respect the ethics of the owners of the CHAM units.

## **ARTICLE 7**

### **ASSIGNMENT**

Neither Party shall assign this Memorandum of Understand nor any part thereof to any part unless prior consent of the party is given in writing

## **ARTICLE 8**

### **GOOD FAITH AND FAIRNESS**

The parties undertake to act in good faith with respect to each other's rights and obligations under this Memorandum of Understanding and to adopt all reasonable measures to ensure the realization of the objectives of this Memorandum of Understanding.

## **ARTICLE 9**

### **SETTLEMENT OF DISPUTES**

1. The Parties shall use their best efforts to settle amicably all disputes arising out of or in connection with this Memorandum of Understanding or the interpretation thereof.
2. Any dispute between the Parties on matters arising pursuant to this Memorandum of Understanding which cannot be settled amicably within thirty (30) days after receipt by one Party of the other Party's request for such amicable settlement may be submitted by either Party to arbitration in accordance with the provisions of the Arbitration Act (Cap.6.03 of the Laws of Malawi).

## **ARTICLE 10**

## **AMENDMENT**

1. Any amendment to this Memorandum of Understanding may be negotiated between the Parties.
2. Any amendment agreed by the Parties shall be embodied in a written document signed by both parties.

## **ARTICLE 11**

### **TERMINATION**

Where, after careful consideration between CHAM and the MOH it has been established that it is not possible for a CHAM facility with an SLA to offer services in a manner that is consistent with the objectives of this MOU, the SLA shall be terminated by either the purchaser or the provider. Any Party wishing to terminate a SLA shall give the other Party three (3) months notice in writing. This however, shall not in any way mean termination of this MOU.

A Party wishing to terminate this Memorandum of Understanding shall give the other Party three (3) months notice in writing.

## **ARTICLE 12**

### **NOTICES**

Any notice, request or any other communication required or permitted to be given or made pursuant to this Memorandum of Understanding shall be in writing and addressed as follows-

For the Government	The Secretary for Health Ministry of Health P.O. Box 30377, Lilongwe 3. Fax No. 01 789 431
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For CHAM	The Executive Director CHAM P.O. Box 30378, Lilongwe 3 Fax no. 01775 406/01 776 492 Email: chamsec@malawi .net
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IN WITNESS WHEREOF the Parties hereto have by their respective duly authorized representatives signed this Memorandum of Understanding on the day and year first above written.

1. For and on behalf of the Government

Ministry of Finance

Signature: \_\_\_\_\_

Full Names: \_\_\_\_\_

Designation: \_\_\_\_\_

Date: \_\_\_\_\_

Ministry of Local Government

Signature: \_\_\_\_\_

Full Names: \_\_\_\_\_

Designation: \_\_\_\_\_

Date: \_\_\_\_\_

Ministry of Health

Signature: \_\_\_\_\_

Full Names: \_\_\_\_\_

Designation: \_\_\_\_\_

Date: \_\_\_\_\_

In the presence of-

Ministry of Justice

Signature: \_\_\_\_\_

Full Names: \_\_\_\_\_

Designation: \_\_\_\_\_

Dates: \_\_\_\_\_

2. For and on behalf of CHAM

Signature: \_\_\_\_\_

Full Names: \_\_\_\_\_

Designation: \_\_\_\_\_

Date: \_\_\_\_\_

In the presence of-

Signature: \_\_\_\_\_

Full Names: \_\_\_\_\_

Designation: \_\_\_\_\_

Date: \_\_\_\_\_

## **Appendix 16: SLA draft framework**

### **Framework for Service Level Agreements**

#### **Background**

Service Level Agreements (SLAs) are health service delivery contracts between local government, government district health offices and private facilities such as Christian Health Association of Malawi (CHAM) and Banja La Mtsogolo (BLM). In line with the Essential Health Package (EHP; See Annex 1) and the Programme of Work 2004 – 2010 (POW), the goal of SLA is to improve equity of access for the poor in areas where the Ministry of Health (MOH) is unable to provide services and where private facilities already exist, but where user fees are charged.

The original intention was to use SLA as a mechanism for fully implementing the EHP. While first SLAs put in place in 2002 covered the EHP and some non-EHP services, the current SLAs focus on maternal and neonatal health. Currently, there are over 50 SLAs in place. (See Annex 2 for a list of CHAM facilities providing free essential health services under a SLA) Whether or not it will be possible to extend the SLAs to the full EHP is still under discussion. Cost implications and staff shortages are the most important challenges in rolling out to new health facilities and at the same time expanding to the full EHP. For the foreseeable future, SLAs will focus on maternal and child health.

It should be noted that many non-governmental health facilities provide other free EHP services outside of the SLAs e.g. tuberculosis detection and treatment, detection and treatment of sexually transmitted diseases including HIV/AIDS, growth monitoring and treating nutritional deficiencies etc. These services are provided free of charge either because of the facilities' participation in specific programmes at community or facility level, or because the patient is exempted from paying user fees according to the CHAM User Fees & Exemption Policy (2006).

The SLAs replace user fees with government subsidies thus removing the financial barrier for poor people to access essential health services. The funding for these subsidies comes out of the District Health Office's Other Recurrent Transaction (ORT) budget. No extra funding is provided to meet the requirements of the SLA. As such, the District Implementation Plan must adequately reflect the cost of administration, provision of services, as well as the cost of monitoring and evaluating the contract. The MOH covers the direct costs of salaries, pharmaceuticals, medical supplies, bed, emergency transport as well as monitoring and evaluation of the contract. The provider covers the indirect costs such as equipment and infrastructure. Historically the fees have been arrived at by mutual consensus. Going forward, however, a standard costing and standard fees will be used.

The Department of Planning and Policy Development oversees the SLAs. The Private Public Partnership Technical Working Group (PPP TWG) provides technical advice and has representation from MOH, CHAM, BLM and the private sector,



## **Selection Criteria**

In the absence of a formal needs assessment, no final target number of SLAs has been set. However, annual targets, which are drawn from the District Implementation Plans are used and monitored. See Annex 3 for a list of potential new sites for FY 07/08. It is not the intention of the MOH to create SLAs with all private institutions (CHAM, BLM or others). Rather SLAs should be implemented when:

1. There is unmet need for the services in the catchment population (the catchment area<sup>7</sup> may not necessarily correspond to the district boundaries) due to:
  - Lack of options – the population does not have access to a government facility or any other facility that provides EHP services free of charge at the point of delivery.
  - Lack of resources (infrastructure or in some cases staffing) at the government facilities such that the facility does not provide the full complement of EHP services.
  - Excess demand for services beyond the capacity of the government facility.
2. All parties must be willing to enter into and commit to a SLA.

## **Process for Implementing SLA**

The following are the steps involved in implementing a SLA:

1. A needs assessment should be undertaken to justify the implementation of the SLA. This should result in a one-page summary that should describe the unmet need (coverage against targets), demonstrate the will of both parties, estimate the costs (financial and otherwise) and indicate a timeline for implementation. This needs assessment should form the basis for preliminary discussions.
2. Consensus for proceeding with the SLA must be reached with the District Assembly, Zonal Health Support Office, CHAM, the provider and proprietor and the Department of Planning and Policy Development.
3. All parties need to dedicate adequate time negotiating the terms of the contract. A template of the SLA contract, which provides the key areas that must be covered in the contract (See Annex 4) is recommended for use.
4. The draft SLA must be reviewed by the ZHSO. The ZHSO is responsible for consulting the Department of Planning and Policy Development at this stage.
5. Once the terms of the contract are agreed, the District Health Officer, District Assembly, CHAM provider and proprietor or BLM must sign the SLA.

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<sup>7</sup> In case a catchment area crosses over a district boundary, two separate SLAs should be signed for each district. Under these circumstances, the caseload is divided using a verification of domicile system.

6. The CHAM Secretariat or BLM must witness the contract. The SLA should be directed to the Department of Planning and Policy Development so that a delegated officer on behalf of the MOH Permanent Secretary for Health can also witness the contract.
7. Copies of the signed agreements should be kept in the DHO office, the MOH and the CHAM / BLM secretariats.
8. To the extent possible, all improvements identified in the inspection visit need to be completed before any payments are made. Such necessary improvements are not part of the cost of the SLA.
9. A publicity campaign should be conducted to ensure that communities in the catchment area are aware of the changes created by the SLA.

## **Monitoring**

Monitoring of the SLAs needs to be done on an ongoing basis:

1. Monthly activity reports need to be sent to the DHO, together with the monthly invoice DHOs need to compile monthly reports, disaggregated by facility, into quarterly reports for ZSHO and proprietor. The format for activity reports is not strictly prescribed, but should include a breakdown of the contracted interventions, relevant HMIS data, proportion of patient revenues covered by SLA revenues, achievements, challenges and strategies to address the challenges of that month.
2. A Steering Committee should conduct biannual reviews
3. The MOH (through the ZHSO or DHO) will conduct quarterly supervision visits according to the Supervision Framework using the supervision checklist (See Annex 5 and 6).
4. The MOH (HMIU) and the private provider secretariat will compile quarterly monitoring reports using the monitoring indicators listed in Annex 7.
5. The ZHSO will evaluate the SLAs in the larger context of reaching the goals of the EHP and POW.

## **Quality of services**

The quality of care is ensured by adherence to the National Quality Assurance Policy in general.

1. An initial assessment by both parties of minimum required staff levels, essential drugs, supplies, equipment and infrastructure. The findings and action points are recorded in an assessment report.
2. Regular (joint) supervisory visits by the DHO, ZHSO, health coordinator representing the proprietor, and/or CHAM Secretariat. The findings and action points are recorded in a supervision report.
3. Unannounced spot checks by the DHO. The findings and action points are recorded in a supervision report.

4. Regular (self-) assessments by the quality assurance team of the provider. The findings and improvement steps are recorded in a quality assessment report. The establishment of quality assurance teams is currently in progress.
5. Adherence to the national patient charter, protocols and treatment guidelines as stipulated in Article 2 of the contract. See Annex 8 for a list of national policies and treatment guidelines.
6. Monitoring of the SLA indicators by the ZHSO and Health Management Information Unit of MOH.
7. Biannual review by the Steering Committee
8. Inspection by the regulatory bodies.

### **Standardized Costing**

SLAs are based on the principle of performance-based or output-based financing. Itemization of inputs is not used. Instead, standardized fees have been calculated to cover the average cost of these inputs. Monthly payments using these standardized fees will cover the number of interventions provided and so the total can be expected to vary. For budgeting purposes, a maximum foreseen monthly payment is calculated on the basis of the intervention targets.

An approved costing framework for EHP interventions within the context of the SLA will apply (See Annex 9) and be revised annually and as is appropriate in the occasion of a revised standard treatment policy or gross currency exchange fluctuations. In principle no other interventions than the costed SLA interventions will be part of a SLA, unless approved by MOH.

### **Renewals**

Unless there are serious difficulties during the term of the agreement that require arbitration, the approach to the renewal of the contract should be one of engaged performance improvement. The SLA is the official recognition of a working relationship between the contractor and provider. Within this relationship, both parties must make honest assessments of the current level of service delivery and constructive criticism for how to make improvements in terms of the working relationship and service delivery. The parties may find it helpful to discuss goals and objectives beyond the year term of the contract to help focus the identification of steps necessary for incremental improvement. Such identified quality improvement steps need to be endorsed and monitored by the Steering Committee.

During the renewal process, the consolidated monthly reports from the facility, biannual reports of the steering committee, the supervision visit reports and quality assessment reports should be consulted. A steering committee meeting should be convened to assess what went well and areas of improvement in the future contract.

### **Responsibilities and Task Allocations**

The major tasks and activities of the stakeholders are shown in a table (See Annex 10). The table provides a description of the key activities and identifies the party or parties responsible for each activity.

## LIST OF ANNEXES

### **ANNEX 1: EHP Components and Interventions**

### **ANNEX 2: Current CHAM Facilities with SLAs**

### **ANNEX 3: Potential new SLA sites for FY 07/08**

### **ANNEX 4: Template for SLA**

Please note that the following template is provided for reference only. Each SLA will be negotiated separately and will therefore results in slight modifications of this form to suit the two parties.

*(Note: attached template)*

### **ANNEX 5: Supervision Framework**

### **ANNEX 6: SLA Supervision Checklist**

The following checklist is to be used by the MOH (through the ZHSO) during routine visits. Other checklists may be used in addition as appropriate

*(Note: attach checklist)*

### **ANNEX 7: M&E System SLAs (Pending Approvals)**

The following are the set of indicators proposed by the PPP TWG. They are currently pending approval. Most indicators are regular HMIS data and will be gathered and compiled under responsibility of the DHO at district level and HMIU at national level. The PPP TWG will review monitoring reports at regular intervals to evaluate progress.

### **Annex 8: List of National Policies and Treatment Guidelines**

### **Annex 9: SLA Cost Range and Recommended Intervention Fees**

Please note that these fees will be revisited annually to identify and address any problem areas.

*(Note: attach fee schedule)*

### **ANNEX 10: Responsibilities and tasks: key activities**